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ABSTRACT

This report provides comprehensive information regarding drug use/abuse. The first chapter describes drugs -- those generally accepted by society as well as those less accepted -- and discusses potential psychic and physical dangers inherent in their abuse. The second chapter explains the reasons offered by drug users for their generally unacceptable social behavior. Chapter three is devoted to drug abuse education and includes a comprehensive State-by-State description of drug abuse prevention programs. Chapter four reviews facilities and programs available for treatment of drug addiction, and describes recently developed treatment methods. Appendixes include an extensive annotated list of resources that may be used to develop educational programs for students, teachers, and administrators. (JF)

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DRUG ABUSE: A CHALLENGE FOR EDUCATION

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PREFACE

The growing rate at which drugs are used by members of our society has caused alarm and concern in many quarters. Nowhere has the concern reached greater proportions than among the parents of the young who, in addition to the many other challenges that confront them in child-rearing, are now faced with the real and awsume fact that their son or daughter may use habituating drugs and become addicted to them. As many have done in the past, today's parents look to those in education for the solutions to the problems inherent in the use and abuse of drugs.

Many educators have recognized their responsibility and committment and have accepted the challenge to provide some possible solutions to the problem. As the seriousness of the problem of drug use by the young of our society has grown and been accentuated, the nature and number of relevant drug use/abuse curricula, teaching strategies and instructional media have also increased. In addition to the educational community, legislators, sociologists, physicians, clergymen, and others have responded to the challenge of drug use/abuse. This has resulted in the drafting of effective legislation, the design and implementation of treatment modalities, and the identification of resources available for the prevention, control, and treatment of drug addiction.

The Board of Directors of the New Jersey Urban Schools Development Council, aware of the growing seriousness of the problem, especially among the youth attending urban schools, requested that a research effort be conducted by the Research Division of the Council to provide a compilation or synthesis of existing information regarding the issue of drug use/abuse. This document is the result of that request. An extensive literature search was conducted to provide the information contained herein; however, due to the relevancy of the topic, and the proliferation of information regarding it, some sources undoubtedly were not uncovered.

In any discussion of the problems and possible solutions regarding the use/abuse of drugs it is necessary, in defining the parameters, to provide a description of the drugs used by individuals and clarify the potential dangers inherent in their use. This document does just that by describing those drugs generally accepted by our society (i.e., alcohol, coffee, tobacco, and others) as well as the less accepted drugs: marijuana, various volatile chemicals, the psychedelics or hallucinogens, the medicines, and narcotics.

Why individuals begin and continue their use of drugs is another area of concern to those who would hope to find the answers to the problem. The taking of drugs in our society, for reasons other than medicinal, is generally frowned upon, yet the rate at which drug taking has increased over the last few years is a basic cause of alarm. The results of investigations conducted to study the attitudes and values of persons involved in the use of drugs are described in the document and provide

information as to the many and varied reasons offered by drug users as rationales for their behavior.

The basic approach toward the treatment of persons who have become addicted to drugs has changed over the years from one of being harsh and punitive to one that is more socially and medically oriented. This shift in attitude has resulted in a greater number and diversified types of treatment facilities, programs and methods that have been initiated by both public and private agencies. This document describes and discusses these many facets of treatment for the general purpose of providing as comprehensive an analysis of the problems of drug addiction as is possible.

Educators throughout the nation have become aware of the critical need for curricula, methodologies, and instructional media that relate to the problem of drug abuse education. In response to this need, a wide variety of teaching strategies have been developed and many are discussed in this document. In addition, current federal efforts are highlighted as well as a comprehensive state-by-state description of drug abuse programs.

Federal and state legislation have played a significant role in the manner in which the control, prevention, treatment, rehabilitation, and education efforts concerning drugs and drug abuse have existed in the past and will be conducted in the future. For this reason, a comprehensive description has been made of the various federal laws that currently exist and those that have been proposed regarding dangerous drugs. Individual state laws vary as to the drugs included and the penalties imposed and no attempt was made to analyze and describe them. However, the interested reader has been provided with the sources from which information may be tapped regarding the drug laws of specific states.

The document also contains an annotated listing of resources that may be utilized in the development of educational programs for students, teachers, administrators, and lay persons.

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DRUGS AND THEIR POTENTIAL DANGERS

This chapter describes the many and varied drugs that are being used and abused in our society today, and also provides a discussion as to the potential psychic and physical dangers inherent in the abuse of each drug.

Although drug abuse practices differ in their legal, medical, and social implications, they illustrate various patterns of drug abuse which are current in modern society -- the child who experiments with model airplane glue, the adolescent who seeks excitement through smoking marijuana, the college student who takes amphetamines to keep himself awake at examination time, the juvenile delinquent who has had miscellaneous drug experiences and is now using heroin, the adult who trifles with suicide by taking an excessive dose of sleeping pills, the "intellectual" who searches for mystical experience through the use of hallucinating drugs, the youth or adult who takes a "trip" on LSD, and the person who administers himself a neighbor's prescription drug are all practicing drug abuse.[1]

The facts about drugs that are used/abused will be presented in an objective manner and are grouped in a quasi-hierarchy of increasing risk. This need for objectivity was underscored by Richard Blum when he stated:

> Clearly...it will be valuable to look at why each of us uses drugs (cold tablets, weight-reducing pills, tranquilizers) the way we do, what the outcomes are, and how one might hope to alter life situations so as to reduce self-endangering behavior in general, not just ingestion of drugs per se.[2]

ACCEPTED DRUGS.

ALCOHOL. Since the use of alcoholic beverages is a normal, or almost normal, part of the cultures of many countries, dependence on alcohol is usually apparent as an exaggeration of culturally accepted drinking patterns. The manifestations of dependence vary accordingly in a characteristic fashion with the cultural mode of alcohol use. In some countries, dependence on alcohol is characterized by the drinking of wine throughout the day, by a relatively continuous intake of alcohol in this manner, and by relatively little overt drunkenness.[3]

In the United States, alcohol is frequently taken in concentrated forms so that dependence is usually characterized by heavy consumption during short periods of the day, by a tendency to periodic drinking, and by overt drunkenness. It (alcohol) was prohibited in the United States, from 1920 to 1933 under the National Prohibition Act commonly referred to as the Volstead Act, after its sponsor, Andrew J. Volstead. The act defined intoxicating beverages as those containing over 0.5 per cent of alcohol and forbade anyone to "manufacture, sell, barter, transport, import, export, deliver, furnish or possess any intoxicating liquor."[4]

COFFEE. This plant derivative contains the mood altering stimulant caffeine -- the most widely known stimulant in the United States. It was advertized for both medical and euphoric uses in seventeenth century Europe. Indigenous to the Near East, coffee at one point was made subject to criminal penalties, including death. Since the effects of

caffeine are relatively mild, its usage is socially acceptable and not an abuse problem.[5]

TOBACCO. The tobacco plant, which contains the drug nicotine, has undergone legal control in varying degrees for centuries. Blum points out that in Mexico in 1575 and Turkey in 1605, officials made strenuous efforts to banish tobacco, well before any evidence related heart disease and cancer to smoking.[6]

Tobacco's effects are due primarily to nicotine. It is an alkaloid which constitutes from 0.5% to 8% of tobacco, averaging about 1.5% in cigarettes. It is one of the most potent drugs known and one of the most toxic, acting with a rapidity comparable to that of cyanamide. Although nicotine in the nineteenth century was used in American medicine as a nauseant, expectorant and anti-asthmatic, it now has no therapeutic applications.

Tolerance to nicotine develops when the compound is taken repeatedly as is evidenced by the confirmed tobacco smokers who are unaffected by amounts of the alkaloid which would cause marked symptoms in the beginner.[7]

MISCELLANEOUS SEEDS AND SPICES. For thousands of years, man has known that certain substances, when taken into the body, could affect the mind in such a way as to cause a person to have visions or hallucinations. Even today man is in frequent contact with innumerable substances, rarely considered drugs but are so in fact, such as morning glory seeds, nutmeg, and Jimson weed or Datura, which, when taken into the body, have a hallucinogenic effect. The Mexican Indians have long used the sacred mushroom to produce visions and hallucinations, while the Indians in the Southwest have used the peyote cactus for this purpose. All of these drugs are rationalized as acceptable, either because they are rarely abused or have been ingrained into our culture.[8]

THE CANNABIS DERIVATIVES: MARIJUANA AND HASHISH.

In the mid-1930's, when marijuana first came into prominence in the United States, Harry J. Anslinger, then United States Commissioner of Narcotics, claimed that "much of the most irrational juvenile violence and killing that has written a new chapter of shame and tragedy is traceable directly to this hemp intoxication."[9] Whether the use of marijuana is viewed with somewhat less alarm today than it was viewed by Commissioner Anslinger in the 1930's is open to debate.

According to the Commission on Narcotic Drugs of the Economic and Social Council of the United Nations,[10] in the course of its long history, cannabis has had many names, such as: "hashish" (Arabia); "kif" (North Africa); "dagga" (South Africa); "ganja," "charas," and "Bhang" (India); "ma jen" (China); "diama" or "maconha" (South America); and "marijuana" (North America).

The term marijuana applies in general to the Indian hemp plant. The intoxicating substance which gives marijuana its activity, generally considered to be a tetra-hydro-cannabinol (THC) derivative is found primarily in the resinous substance present in the flowering tops of the unpollinated female Cannabis sativa. Although marijuana may be taken into the body in several ways -- by chewing the leaves, by sniffing it in powder form, by mixing it with honey for drinking, by making it into candy for eating -- in the United States, it is assimilated most frequently by smoking.

The potency of marijuana varies with the geographical location in which the plant grows, time of harvest, and the plant parts used.[11] For example, the concentrated resin is approximately six times more powerful than the leaves. A derivative known as Hashish, is a pliable paste when first produced and comes in balls, rods, bars, and especially in sheets with a thickness and consistency similar to shoe leather. Hashish has become increasingly available in the United States because of its potency and is easier to conceal than marijuana.[12]

Although marijuana is legally classed as a narcotic by both federal and state laws, its action on the body is less clearly defined, less uniform, and less predictable than that of the opiates or of alcohol, with which it is sometimes compared. At the White House Conference on Narcotic and Drug Abuse, it was pointed out that lack of adequate research has left great gaps in our knowledge about marijuana and its effects upon those who use it.[13]

Marijuana users report lightness in the head, feelings of total relaxation, peacefulness and serenity, some loss of bodily coordination, intensified sensory perceptions, and a distortion of time. Occasionally they note swings of mood between great joy and extreme anxiety, and hallucinations in which objects change shapes and colors or unreal visions appear. The known physical effects include increased heart beat, hyperphagia (i.e., mouth hunger making users crave food and sweets), reddened eyes and reverse tolerance.[14] Because there is a general resemblance between the effects of marijuana and the effects of alcohol upon the human system, marijuana smokers sometimes use this resemblance in an effort to rationalize the legalization of marijuana use.

According to the World Health Organization's Expert Committee,[15] marijuana dependence rests upon two psychological elements of dependence -- desire and psychic dependence -- and these are the most compelling and the least reversible aspects of drug dependence. This form of dependence, once established, is exceedingly difficult and often impossible to break because the individual involved seeks characteristically to duplicate and deepen his original experience with the drug, consequently reinforcing his dependence on the drug. In the words of Ausubel:

> Despite the claims of (marijuana) users that they can voluntarily discontinue use at any time without experiencing undue suffering or craving, their

> behavior indicates otherwise...Confirmed users bitterly resent deprivation and readily admit their future intentions to return to the drug as soon as conditions permit.[16]

THE VOLATILE CHEMICALS.

Among non-drug substances frequently encountered in drug abuse are the commercial volatile chemicals (i.e., glue, gasoline, paint thinner, lighter fluid and marking pencil fluid). They contain volatile hydrocarbon solvents which are allowed to evaporate in closed containers and are then inhaled to produce the symptoms of intoxication which the user desires. The hydrocarbon content varies from one source (of hydrocarbon vapors) to another and the effects vary with the hydrocarbons present, the amount inhaled and the condition of the user.[17]

Evidence exists that solvent inhalation leads to the development of tolerance and psychic dependence. It does not indicate, however, that physical dependence develops. The chief medical dangers of inhalation of concentrations of hydrocarbon vapors are: (1) death by axphyxiation -- the person loses awareness or becomes unconscious while inhaling the hydrocarbon vapors in a confined space such as a plastic bag; (2) the development of psychotic behavior; and (3) the state of intoxication these substances produce. It is known that many solvents and the ingredients of some types of glue can affect liver and kidney action, cause damage to vital centers of the brain, interfere with the blood-forming function of the bone marrow, precipitate irregular heart rhythms and a depression of the central nervous system. Although much adverse effects upon the human system of inhaling volatile chemicals have not been established they remain a distinct possibility.[18]

THE PSYCHEDELICS OR HALLUCINOGENS.

LSD. The use of the drug, LSD[25] (d-lysergic acid diethylamide tartrate), commonly referred to as LSD is one of the most potent of the hallucinogens. According to Stanley F. Yolles, M.D., Director, National Institute of Mental Health "the usual dose is about 100-200 micrograms or one-fifteenth to one-thirtieth millionth of an ounce."[19] On the illicit market, the drug may be obtained as a small white pill of varying shapes and sizes, as a crystalline powder in capsules, or as a tasteless, colorless or odorless liquid in ampuls. Frequently it is offered in the form of impregnated sugar cubes, or animal crackers.

The mechanism by which LSD affects the human mind is still unknown. According to the factors involved in drug dependence (See Appendix A - Definition of Terms) LSD does not cause physical dependence with withdrawal symptoms but does cause severe psychological dependence. Desire to continue taking the drug is present, and LSD users, in contrast to users of hard narcotics, often develop a missionary or proselytizing quality. LSD is an idiosyncratic drug in that every individual has a

different reaction to it. An unusual effect of LSD is that a person can have a recurrence of symptoms, in all their original intensity, many months after taking LSD without having taken any more of it during that period of time. Four major types of acute symptoms have been identified after LSD ingestion: (1) illusions and hallucinations; (2) anxiety, often to the point of panic; (3) severe depression with suicidal thoughts and attempts; and (4) confusion, often to the point of not knowing where one's self is. The occurrence of these symptoms is totally unpredictable.[20]

Prior to the legal ban on LSD, a limited amount of information had been obtained regarding the patterns and extent of its use from studies of persons who had sought medical help and from studies of its use in community groups. Subsequent to the passage of laws forbidding the use of LSD except for authorized investigational research, it has become difficult to ascertain precisely how LSD is being used and to what extent it is being used. Nevertheless, the evidence that has been gathered on the illicit use of LSD and other hallucinogenic drugs points to: (1) changing patterns of use; (2) greatly increased use; and (3) use by younger persons.[21]

Dr. Timothy Leary, who first hymned the values of LSD trips, has recently been telling students:

> LSD is not for everybody. Perhaps fewer than 10% of Americans are designed to become the astronauts of the consciousness. I want to warn you: It is a very powerful drug. Don't be pressured into taking it by your friends.[22]

PEYOTE AND MESCALINE. Peyote (pay-OH-tee) is a hallucinogenic substance obtained from the fleshy fruit of the peyote cactus plant -- an ugly, cucumber-like plant which is found in the Southwest. It was discovered centuries ago by Indian tribes of Mexico and the United States Southwest. It is usually taken by mouth (the chewing of shriveled brown "buttons") and is used by native religious sects who undergo hallucinatory experiences in groups as part of their ceremonies.

Mescaline (derived from the Mexican cactus, peyote) is the most active of the 17-odd alkaloids found in the peyote cactus. Mescaline is available on the illicit market as a crystalline powder in capsules or as a brownish-gray liquid in ampuls or vials. Because of its bitter taste, the drug is often ingested with tea, coffee, milk, orange juice or some other common beverage.

Mescaline is chemically related to amphetamine and has its most pronounced stimulating effect on the vision, allowing colors to seem more bright and profuse. The over-stimulation of the visual cortex results in wavering outlines and other distortions similar to those found with LSD. The big difference between mescaline and LSD is that mescaline does not seem

to provoke the rapid emotional changes often experienced with LSD. Recently, this more "controlled trip" has become far more popular, making mescaline, once an esoteric hallucinogen, more in demand and more available than LSD. [23]

RARER HALLUCINOGENS. Psilocybin is either produced synthetically or is extracted from mushrooms grown in Mexico. It has been used in Indian religious rites as far back as pre-Columbian times. It is not nearly as potent as LSD, but with adequate doses, similar hallucinogenic effects are produced. Psilocybin is available in crystalline, powdered or liquid form.[24]

DMT. DMT (di-methly-triptamine) is a short-acting hallucinogen and although prepared synthetically, is a natural constituent of the seeds of certain plants native to the West Indies and parts of South America. The powdered seeds have been used for centuries as a snuff called "cohoba" -- used in religious ceremonies to produce a state of mind which the Haitian natives claimed enabled them to communicate with their gods. DMT and the similar DET (di-ethyl-triptamine) are not taken orally, but their vapor is inhaled from the smoke given off by burning the ground seeds of powder mixed with tobacco, parsley leaves, or even marijuana.[25]

DOM. DOM, commonly known as STP (methyl dimethoxyamphitamine) is a very complicated hallucinogen similar to LSD. STP is almost 200 times more powerful than mescaline but one-tenth as potent as LSD. STP is not found in nature but is synthesized in the laboratory and has appeared in illegal channels in tablet form.[26]

MDA. MDA (methylene-diethyl-amine) is a recent addition to the roster of synthetic hallucinogens. Similar to mescaline, it is easier and cheaper to make and is often sold as mescaline. It produces a four to twelve hour trip, but without the calmness usually produced by pure mescaline.[27]

THC. Not a true tetra-hydra-cannabinol, THC is also known as PCP or benactizine. It is an animal tranquilizer which produces four to six hours of listnessness and lack of any motivation. Sold by dealers as a substitute for other drugs, PCP is rarely found now that its real nature is well known.

None of the hallucinogens produces physical or psychological dependence. Like LSD, their effects are to the emotions.[28]

THE MEDICINES.

AMYL NITRITE. A volatile chemical, Amyl Nitrite has long been used by doctors to help angina pectoris victims. Only recently changed from an over-the-counter drug to a prescription item, it comes in ampules. Whem sniffed, it dilates the small blood vessels and users obtain immediate, though short-lived rushes of warmth, giddiness and,

according to some, sexual stimulation.[29]

DEPRESSANTS. The barbituarates are central nervous system depressants (also referred to as sedatives, or hypnotics) used medically for the relief of nervousness, tension, and anxiety, and in various other conditions in which sedation or anesthesia are indicated. The individual members of the barbiturate family differ from each other primarily in speed of action and duration of effect. They range from the short-acting, fast starting yellow capsules of Nembutal ("yellow jackets") and the red capsules of Seconal ("red birds") to the orange-yellow pills of the depressant Thorazine, often used to control agitated mental patients and by drug users as an antidote to the effects of LSD. Other barbiturates are the bluish-brown capsule of Librium, the long-acting, slow-starting Amytal, Butisal and Luminal ("purple hearts").[30]

Most serious today is the practice, widely used by juveniles, of combining barbiturates with alcohol. This combination is dangerous because the barbiturates interfere with the body's normal disposition of alcohol, and the two drugs, working together, have a total effect greater than the sum of their individual effects.[31] Irresponsible use of the barbiturates may cause drug dependence. The characteristics of barbiturate dependence, as described by the World Health Organization's Expert Committee, include: (1) a strong desire or need to continue taking the drug; (2) a tendency to increase the dose, partly owing to the development of tolerance; (3) psychic dependence on the effects of the drug; and (4) physical dependence on the effects of the drug.[32]

STIMULANTS. Best known for its ability to combat fatigue and sleepiness, amphetamine is a central nervous system stimulant. It also is sometimes used to curb the appetite and has thus played a role in weight reduction for some people who are incapable of exercising self-control over their food intake. Amphetamine is most commonly available as amphetamine sulfate, a whitish powder available in various forms -- tablets, ampules, capsules, and solution. Amphetamine and its chemical variants are marketed under various trade names the most common of which are Benzedrine and Dexedrine, small white or orange pills roughly the size of aspirin.

Notorious is the abuse of these amphetamines by: wildcat truck drivers who, in making long hauls, dose themselves with this drug to keep awake for long periods rather than to take the time required to get the sleep they need and by college students by offering the possibility of remaining awake and alert all night especially during examination periods.[33]

Cocaine is the active constituent of the leaf of the South American coca plant (Erythroxylon coca), which is grown in the mountainous regions of Peru. In the United States cocaine was at one time widely used as a local anesthetic, but it has now been largely replaced by synthetic substitutes, such as procaine and novocaine. On the illegal market cocaine ordinarily appears as an odorless, white, fluffy, crystalline

powder similar in appearance to snow. Cocaine may be snuffed into the nostrils or it may be injected intravaneously directly into the bloodstream. In either case, the result is a strong stimulation of the central nerous system, and this stimulation, in turn, causes the accustomed user to feel exultant, animated, and energetic. Though cocaine does not produce physical addiction, the craving for its extreme "high" can produce strong psychic dependence.[34]

The term "speed" is slang for various kinds of amphetamines, including the above mentioned Benezedrine and Dexedrine, but most commonly denoting Methedrine. It (methedrine) is a fine white powder that looks like milk sugar and in varying doses, may be taken orally, sniffed into the nostrils, or injected intravaneously directly into the bloodstream. The latter is the method of the "speed freak" who seeks the "meth high" via doses of six to 200 times the daily medical dosage usually prescribed for dieters. Chronic use can lead to a psychosis that many doctors feel is more similar to schizophrenia than any of the psychotic symptoms brought on by other dangerous drugs. In addition, researchers currently suspect that permanent brain damage resulting in serious, delayed psychoses is another legacy of "speed."

Although amphetamines generally are not considered physically addictive, they do create tolerance requiring consumption of increasing amounts. Amphetamine users do not develop total dependence, but they may develop psychological dependence upon the drug if the user tries to alleviate the depression he suffers when the effects wear off by starting in all over again.[35]

THE NARCOTICS.

MORPHINE. Morphine is an odorless, white crystalline substance deprived from opium. It acts on the central nervous system as an analgesic or painkiller. It is a very powerful drug and can be used safely only in small, carefully controlled doses. When morphine dependence occurs in the course of medical treatment, it is more readily curable than self-induced dependence derived from the illegal use of narcotics because psychological dependence is not ordinarily present in such cases.

Morphine is legally available in the United States only to physicians for use in the alleviation of suffering and is no longer available in patent medicines, as it was when thousands of soldiers became addicted to it during the Civil War. Morphine is obtained illegally, however, by a variety methods: thefts from doctors' offices and automobiles, forging of prescriptions, and thefts from stored supplies. Because the drug thus obtained is pure, it is likely to be stronger and more potent than the diluted morphine or heroin available on the illicit market.

Codeine (methylmorphine) is derived directly from the opium or prepared

from morphine. It is comparable to morphine in its analgesic and addictive properties but is considerably milder in its effects. It is a valuable medicinal drug used principally as a pain-reliever and a cough suppressant. Diverted occasionally from legal medical channels, codeine may be used for the maintenance of addiction or as a temporary replacement for morphine or heroin.[36]

OPIUM. The Papaver somniferum, known as the "opium poppy", thrives in a hot, dry climate and is grown in such countries as India, Turkey, China, Egypt, and Mexico where land and labor are cheap. The flowers, leaves, stems and roots of Papaver somniferum have no narcotic properties, nor do its ripe seeds. However, the unripe seed pods from this plant do have narcotic properties. The narcotic drug called opium is prepared from the juice of these pods. It should be noted that Papaver somniferum is the only species of poppy which yields opium. Morphine, which is a principal alkaloid or active constituent of opium was discovered early in the nineteenth century. At the turn of the century some 200,000 United States citizens were addicted to some form of opiate -- a level vastly higher than the estimated .03% - .05% addicted to narcotics today. Opium is not used to a great extent in the United States today, chiefly because heroin is less bulky and easier for underworld agents to import and distribute.[37]

HEROIN. Heroin (diacetylmorphine) is a semi-synethetic derivative from morphine, which in turn is a constituent of the unripe seed pod of a particular species of poppy, the Papaver somniferum. It (heroin) is a fine tan powder, odorless but with a bitter taste, and is derived from morphine by means of a simple chemical process. Ironically, it was first promoted as a non-addicting substitute for morphine and as a possible cure for morphine addiction. The inherent dangers (i.e., the possibility of contracting disease) in the often-times crude procedure used by the addict for taking a "fix" are over-shadowed by the inevitability of scarred or sclerotic veins -- veins whose walls have deteriorated from repeated puncturings. Heroin exerts its depressant effect directly on the nervous system and indirectly on all physiological activities of the body. As far as is known, the opiates do not themselves cause tissue deterioration or destruction, but the addict, in his preoccupation with drugs and the means of securing them, is prone to neglect his health. The result, in time, may be severe malnutrition, dental caries, chronic fatigue, lowered resistance to infection, and a generally devitalized condition. Occasionally, users have a fatal reaction even before the needle leaves their arm, and although doctors are not sure what causes it, they suspect it may be related to the substance with which heroin vendors adulterate the powder.[38]

The most important effect of heroin use, from the standpoint of the user, is euphoria -- the sense of well-being and contentment, which he experiences or attempts to experience immediately after his injection. This sensation is his objective in taking narcotics, and this is the basic reason for the high rate of relapse among "cured"addicts. The

extent to which the individual enjoys this sensation is dependent upon several factors, such as the strength of the dose, the expectation of its effects, and the degree of tolerance already developed in his system. Once physical dependence is established, however, the heroin user is likely to claim that he derives no pleasure from the use of the drug but that he is bound to it by the necessity of warding off the torture of the withdrawal illness which threatens him whenever his body is deprived of heroin.[39]

The characteristics of heroin dependence are comparable to those of morphine dependence, which the World Health Organization's Expert Committee describes as: (1) an overpowering desire or need to continue taking the drug and to obtain it by any means; (2) a tendency to increase the dosage because of the development of tolerance; (3) a psychic dependence on the effects of the drug; and (4) a physical dependence on the effects of the drug.[40]

FOOTNOTES

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[31]"Dependence on Barbiturates and Other Sedative Drugs," The Journal of the American Medical Association, CXXII, (August, 1965), p. 675.

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[35]Cory and Godfrey, op. cit., pp. 11-12.

[36]Kitzinger and Hill, op. cit., p. 52.

[37]Cory and Godfrey, op. cit., p. 12.

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RATIONALES FOR THE USE OF DRUGS

The main emphasis of this chapter is directed to a discussion of the various reasons offered by drug users for their generally unacceptable social behavior.

If educators are to find solutions to drug use, they must first be aware of the reasons why youth and adults in our society use drugs. The reasons offered for using drugs are both old and new, and some of them seem somewhat reasonable and are difficult to condemn in an absolute sense. The concerned educator must recognize the existence of two realities in his investigation of reasons or causes for the use of drugs; his own and that of the youngsters. The social and psychological pressures of our society that make for drug taking must be respected and the solutions to the problem must operate within their context.

The reasons youth become involved in the taking of drugs are many and varied. Each and every person who uses drugs in a sense has their own individual reason or motivation. According to the mores of our society, however, drug use is considered a taboo and is in direct contradiction to the way an individual is supposed to behave. It becomes evident, therefore that a new particular set of attitudes and values has been adopted by those who indulge in the use of various drugs.

Attention has been focused on the question of attitudes and values that prevail among drug users and the professional literature has reported the findings of those who have studied the matter. Analysis of these findings suggest that specific categories may be established. In any discussion of these categories, it must be remembered that the availability of specific reasons or motivations does not mean that a person who uses drugs will neatly fit into a specific category. As previously stated, an individual may have many reasons for his behavior and may very well fit into a number of categories.

It should be pointed out that the order in which the categories of prevailing values and attitudes discussed in the following pages does not suggest any priority that may have been assigned by drug users.

REASONS FOR DRUG USE.

CHANGING MORES. The general acceptance in our society of the use of mood-altering pills has had its effect upon the increased use of non-legitimate drugs and has been offered as a rationale by those who take them. In effect, the taking of "something" to change one's mood has been condoned for centuries by people of many cultures. In our present day society, it is merely impossible to escape from newspaper, television, and magazine ads that tell us relief is just a swallow away for any condition, from nervous tension to drowsiness. Drugs can be considered a form of medicine. When asked to explain (i.e., justify) their behavior, teen-age drug users often point to that fact. Young people realize that drugs can be abused but often feel that their parents use of tranquilizers, barbiturates, amphetamines and alcohol is more irresponsible and dangerous than their own use of marijuana and LSD.[1] Dr. Harold S. Feldman, a New Jersey psychiatrist who runs an addict rehabilitation program at the Essex County Penitentiary, has provided an interesting description of this factor:

> The kids get up in the morning and standing on the breakfast table is a big bottle of vitamin pills. Then, Dad has a big business deal coming up that day and he's feeling a little jittery -- so Mom slips him a couple of tranquilizers.
>
> Dad goes off to the office and Mom gets feeling depressed. She knows she's an attractive well-educated woman and feels she should be doing more with her life than being tied down to a household of screaming kids. So she swallows a couple of anti-depressants.
>
> Dad comes home from the office and the business deal didn't go very well -- so he needs some more tranquilizers. Both Mom and Dad are upset and they're not going to sleep very well -- unless they take sleeping pills, which they do.
>
> We're living in a drug society, where drugs are frequently abused. Is it any wonder that so many kids get involved with drugs?[2]

Many may read the fore-going and feel that it may be interesting and even very valid. However, they might question its relevancy to situations that they know of personally because the parents of youngsters who have become drug users just don't behave that way. If this is the case, it might be well to point out that relative to the matter of mood-changing, individuals may possess particular personality characteristics which influence their inclination to take drugs even in the absence of parental "models" as described by Feldman.

Brehm and Back[3] have reported that their studies reveal the conditions which influence the inclination to take drugs stem from dissatisfaction with one's self and lack of restraints to use drugs as a mechanism for change in mood. Two restraints that may be relied upon are fear of lack of control and fear of bodily damage. For persons where both factors work consistently, prediction of inclination to drug use is quite effective. Where both factors work inconsistently, clearly other influences might become more effective. In these groups of persons, it would be advantageous to consider the prospect of situational and social influences and for additional psychosomatic conditions.

In their survey of campus drug use as reported from health services and counseling centers at United States and Canadian colleges and universities, Murphy, et. al. reported that: "despite the fact that attitudes about drug use were found to be largely guarded, where responses were given, the consequences of drug use were more often viewed as negative than positive and intra-psychic difficulties rather than environmental factors were identified as the primary cause of drug use."[4]

THE BASIC IMPULSE FOR PLEASURE OR FUN. Another influence that society, in general, has had upon the use of drugs has been the increased emphasis in our culture for doing things that are pleasurable or fun. Untold amounts of money are spent each year in the United States on activities that are designed to get us away from it all. Like the neolithic men who got "high" on fermented berries and the Assyrians who sucked opium lozenges, many of today's drug users are seeking pleasure by getting "high" on drugs. When a young seminarian student was asked in a magazine interview what he felt he received from using drugs, his answer was -- "pleasure."[5]

BOREDOM. Associated with the seeking of pleasure and fun from the use of drugs, is the reality that many of today's youth are bored. They seek pleasurable thrills to replace dullness and boredom with moments of exhileration and danger.[6] Child study experts know that young people now mature faster than their parents did both intellectually and physically. It appears that the sorts of activities that schools and communities traditionally have provided for adolescents are no longer demanding enough to keep their attention. In part, vague purposelessness may also grow from a sense of frustration of having too many choices available, or what columnist Max Lerner calls:

> a pround national crisis of belief, of unbelief. Its cause -- beyond war and crowded ghettos and impersonal campuses -- is a basic rootlessness that has stripped a whole era, and not only a generation, of the sense of belonging that earlier earas had in America. The prevailing symptom is a desperate feeling of emptiness, and with it the yearning to fill the emptiness with anything -- kicks, adventures, bizarre cults, (and) drugs. . .[7]

Students are sincerely looking for something better in our society, perhaps for real meaning and happiness or relief from the boredom or hollowness in materialistic life.[8]

REBELLION. Young people may begin using marijuana or other drugs as a way of expressing estrangement from a group to which they belong, (e.g., a sensitive young person rebelling against his family).[9] Young people in the influential American middle class, brought up in a world where everything came easy, are creating an entirely new culture in which to function. This new culture finds something distasteful in the reality most adults know and accept. To youth, that world has become remote, uncaring and insensitive.

According to Richard Bratman, a mental hygienist, experiences with older adolescents and young adults have indicated that drug use does not appear to be immature rebellion but one facet of dissent against the values and mores of the general social culture.[10] Lipinski and

Lipinski have reported that the taking of psychedelic drugs is one way for the student to establish autonomy and undergo an experience and viewpoint which few people in the "establishment" share.[11]

Students are constantly faced with contradictory messages by the adults in the college community. On the one hand they are told to be adult and prepare themselves for roles of leadership and responsibility; while on the other hand they feel that rules of behavior, areas of competence, and the levels of function appear to be predetermined.[12] The use of drugs by students in these situations provides them with a mechanism for rebelling against the structure of the college or university which for the most part has assumed a role of substitute parent(s).

THE QUEST FOR AUTHENTIC EXPERIENCES. Amherst Professor and critic Benjamin Demott has written that in the decade of the 1960's, "young, old, black, white, rich, and poor alike are pursuing the dream of a more vital experience."[13] Life today, despite the luxuries that abound and the general prosperity that exists is for many empty and meaningless. Some drug users claim that drugs give them increased sensitivity of heightened powers of creativity, that ordinary, more conventional means of stimulation can not.

The emphasis on the pursuit of academics, whether it be at the high school or college level, combined with the social turmoil the nation finds itself involved in, leads students to seek the answers to such questions as: "What is the meaning of life? What is the sense of it all? Why must there be social injustice? What really matters? The response or responses to these questions are offered to students and to the general public as well; but in such an abundance that we become psychologically numb because of them. The exposure to a variety of ideologies, value systems, philosophies, political creeds, superstitons, religions and faiths become desensitizers. This "stimulus flooding" and the resulting psychological numbing," as Keniston[14] calls it, leads students on a search for significance and relevance through the use of drugs.

In addition, youth tend to concentrate on the present, on today, on the here-and-now. As a result, they cast aside any reverant feelings for traditions of the past and seek experiences in the present that will provide them with meaning and insight to the pressures and problems that confront them. Activity, adventure, responsiveness, genuiness, and spontaneity have become new experiential values. Since neither the future nor the past can be assumed to hold life's meaning, the meaning of life must be sought within the present experience, within the self, within its activity and responsiveness in the here-and-now.[15] To some these experiences are more attainable, more real, more relevant when they are under the influence of drugs.

According to Finestone,[16] the quest for a superior sensitivity and a unique experience, two rationales offered by those involved in drug use, are particularly attractive to "marginal men" who have not been very successful in fulfilling their aspirations for achievement in the conventional world. It has been suggested that this may explain why the drug habit attracts adolescents, especially those previously involved in delinquency, and thus handicapped in achieving their adult aspirations.[17]

PHILOSOPHY. Still another explanation offered by those who experiment in drug use centers around philosophy. The ultimate aim of both religion and philosophy has always been the determining of various cosmic questions. Young drug users say drugs help them seek subjective answers to the types of spiritual questions that LSD experimenter Dr. Timothy Leary, one of the drug culture's first spokesmen, defines as the essence of the religious experience, namely; (1) "What is the cosmic plan? (2) What is life, where did it start, where is it going? (3) What is man? and (4) What am I?"[18] Thus, some of the people who use drugs feel that chemicals are a shortcut to the realization of God.[19] Drugs, therefore, have the potential to create the mystical experience necessary to achieve this end, given the proper psychological set, setting, and guidance. From these mystical experiences will come crucial insights into personality problems and emotional "hang-ups," as well as a new vision of life in terms of loving relationships.[20]

A most natural question arises from the rationale just offered: "Why don't young people turn to the traditional institution of the church in finding the answers to these questions?" An answer to this basic question is suggested by Murphy,[21] a clergyman, who has stated:

> . . .in many ways and in many places the church stands as a viable, brick-and-mortar organized symbol of nostalgia, offering the old answers to old questions about a way of life at a time that is not coming back. Young people recognize this and are keenly aware of the church's failure to live up to the ideals it talks about.

ESCAPE. Another reason for drug taking is to escape from the pressures of society and to flee from difficult problems of character or emotion. Many young people become tense from the fact that their academic accomplishments do not measure up to the aspirations and goals that their parents may have set for them. Despite their efforts they just don't realize the ambitions they have been told to achieve. As a result they create within them deep-seated feelings of inadequacy with associated profound feelings of shame. Their use of drugs becomes a means of finding a solution to these personal problems. These youngsters seem to hope for some sort of magical cure for their emotional turmoil without undergoing, as seen through their eyes, the shameful experi-

ence of working out their problems in the presence of another person (e.g., a therapist) whom they fear would scorn their secret weaknesses.[22]

Other young people want to escape from being caught up in a web of frustration, obligation, or hypocrisy; they refuse to fall victim to the fate they observe in so many adults -- an exhausted giving-in to life's inevitable problems.[23] Drug taking provides an opportunity to enter into an unrealistic world where all of life's problems and tensions are removed.

It should be emphasized that relief or escape from pressures and personal problems is not just something that young people use drugs to accomplish. Adults also fall victim to these same anxieties as reported by Bloomquist in his treatment of drug use by physicians:

> The individual may be adjusted to society to the point where he can function both professionally and socially quite satisfactorily. But the adjustment is frequently marginal. When problems arise, there is rapid retrogression toward anything that offers shelter and protection. If, during this unreasonably unstable period, the narcotic prone tastes narcotics, he suddenly realizes he has found a cork that will seemingly plug the hiatus in his personality.[24]

SOCIALIZATION. Peer influences, the desire to be one of the "in" group, is another strong motivation to young people to use drugs. Being able to talk to friends about experiences while under the influence of drugs may be a passport to acceptance or to heroic elevation. Such users are taking drugs as one way of being like other people they wish to socialize with.

Smoking marijuana is often a social activity. The user is usually helped by others to learn how to enjoy the drug. In addition, there is a satisfaction of reinforcing the in-group feeling that what they are doing is sharing a forbidden pleasure. One college student has expressed this feeling of socialization by comparing pot parties to the drinking parties that were more prevelant on college campuses ten or fifteen years ago. "When people get together for anything from a birthday party to any sort of social gathering, instead of passing the bottle, they pass a joint. It's a means of socialization."[25]

MOTIVATIONS AS A FUNCTION FOR THE USE OF DIFFERENT DRUGS. Richard H. Blum and Associates, conducted extensive research in the area of drug use in the United States and investigated the reasons why youth and students use drugs. The results of this investigation suggests that different motivations may apply as a function for the use of different drugs. The marijuana user may have certain reasons for taking this particular drug; whereas, the heroin user may have a different reason

for using heroin. It was found that opiate users responded positively to all reasons provided as possibilities; (i.e., relieve of tension, to feel stronger, to feel less dull, and to satisfy a strong craving). Thus, it is suggested that opiate users use them for almost any felt need or motivation. Blum found that users of tranquilizers more than any other class of drug users employ these substances to relieve tension and avoid panic. Amphetemine users emphasize the use of drugs to feel stronger and to be less dull.

Blum's study further reported that marijuana users tend to use the drug more for reasons of self exploration, religious seeking, combating of depression, mood elaboration, enhancement of friendliness, sexual improvement, sexual reduction, avoidance of panic or psychosis, suicide attempts via drugs, enhanced learning or recall, and insulation from stimulation. Hallucinogen users are motivated for reasons of self-exploration, religious seeking, relief from boredom, combating of depression, mood elaboration, sexual-appetite enhancement, learning facilitation, stress preparation, and insulation from stimuli. Persons use sedatives for reasons of tension relief, reduction of sexuality, and suicide attempts via the use of drugs.

In summary, Blum reported that the greatest variety of motives for drug use was offered by the opiate users, followed by special substances users, amphetemine users, and pot smokers. Blum stresses that the reasons given by drug users for their indulgence implies that distress is present within the psychological makeup of the individuals. He also points out the implications of the fact that persons who have claimed the use of drugs based on functions reflecting psychological pain have used drugs for these distress-reducing reasons.[26]

POSSIBLE SOLUTIONS. Armed with this arsenal of information that may lead to insight and revelation regarding the why's and wherefore's of drug use by youth and students in our society, one may naturally ask the questions: "Now what," "What do I, as a concerned, interested educator, do with this knowledge that I have been provided with? What are the solutions, if any?"

Blum suggests that the solution lies in education and dialogue, -- two-way communication between those who would solve the drug use problem and those who do not see it as a problem.[27]

Commenting on potential solutions to the problem, Salisbury and Fertig have said:

> Teachers and parents refuse to communicate with the young about the problem (drug use) and to recognize the fact that many students regard smoking marijuana as a normal kind of social activity which is not dangerous to their health or their morals.

If we are going to handle this problem adequately, teachers, counselors and school nurses must learn to overcome their fear of intimacy with their students and begin to communicate with them. Edgar Fridenberg, in his study of a Midwestern high school, The Vanishing Adolescent, found that most of the teachers were afraid of intimate relationships with their students. Most of them, he felt, were motivated by a fear that their aura of authority would be undermined. He found the students were bitter about the absence of any nitty-gritty discussions of life's real problems. Most of them regarded the high school program as 'irrelevant' to their lives, and remained only to obtain the 'certificate' passport to jobs and college. This problem, frankly, rather than any inherant quality of the drugs, is the reason that academic motivation drops precipitously with the excessive use of marijuana. It does not de-motivate the artists and writers who use it, because they are involved in creative work which has deep, personal meaning.

Whatever the reason, the fact is that most teachers are afraid to get involved in discussing their students' real personal problems. Such discussions are emotionally strenuous and most teachers are already overworked.

Yet, if we are to give our young people the ability to face the real world, and if we are to break the vicious circle of the self-fulfilling prophecy in drug abuse, we must learn to confront our students honestly. We must learn the scientific facts about the drugs so we can confront them with meaningful evidence rather than outworn prejudice. With this combination of courage and information, a meaningful dialogue between young poeple and their teachers and parents can begin. This process of legal suppression can never be a substitute for this dialogue.[28]

FOOTNOTES

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DRUG ABUSE EDUCATION

This chapter discribes many of the instructional approaches available to educate youth about drug use/abuse and provides an analysis of their effectiveness. Other items presented in this chapter include the efforts of the federal government in drug abuse education and a comprehensive state by state description of drug abuse programs.

Discussions about drug abuse education often reflect the fact that there exists a lack of consensus on goals. The goal of much of the federal government's educational activity is to prevent the use of illegal drugs and those that are potentially harmful. It is recognized that laws alone have not prevented abuse and cannot be expected to do so in the future. The goal of many other current educational programs is to present enough information so that students or audiences can make rational decisions for themselves. This second goal does not necessarily include a proscription against use. A third type of goal appears to be that of increasing understanding of all the factors that account for drug use and related social attitudes and policy. There is an implication in some of these programs that social attitudes should change and become more neutral or positive for some drugs, especially marijuana. [1]

CONCERNS REGARDING DRUG ABUSE EDUCATION.

The sociologist Geis has raised some concerns regarding drug abuse education. He wonders whether there is any basis for believing that it can achieve the goal of prevention, especially prevention of narcotic use. Three possibilities are mentioned by Geis as unpredicted consequences of narcotics education that can make it a double-edged phenomenon: [2] (;) a fear of drugs may be reduced to the point that behavior opposite to the intended goal will result. The British Dangerous Drug Law warns that education might make drug taking exciting and therefore attractive; (2) even if drug abuse education had no detrimental affects, it may be quite ineffective. Parents may be satisfied and comforted by the fact that their children were learning about hazards of drug use while the young themselves remain entirely unaffected by the activity; and (3) that drug abuse education may improve the rapport between teacher and pupils while students' knowledge or attitudes remain unchanged. The subject matter itself, because of its popular interest, may engage the interest of students, yet result in very little learning.

Geis' questions reflect the fact that much ignorance still prevails about the effects of drug abuse education, both immediate and long-range. Few would say, today, however, that one could return to a state of untutored innocence.

STRATEGIES USED IN DRUG ABUSE EDUCATION.

In examining the various methods[3] used in drug abuse education, it may be beneficial to consider the effectiveness of these methods in other areas of life and to, then, consider their feasibility in drug abuse education.

SCARE TACTICS. Typically, whether it is a leaflet, a film, a lecture, or some other form, the hazards of taking drugs are the main focus. The expectation on the part of the educator is that recall of negative reinforcement will lead to avoidance of the drug. This variety of education has been severely criticized; that at a minimum, the method is ineffective. The evidence for such criticism was seen long ago in Janis and Feshbach's experiment in dental health education.[4] They

found that the use of horror pictures of diseased teeth was less effective in changing practices than a more neutral approach, for instilling good dental habits.

Another criticism is that credibility is strained by implications in the messages that "Possibility equals Probability." This is the assumption that because a few frightening results have occurred, it is inevitable that they will occur to all who use the drug. Another questionable assumption in some materials is that "Correlation equals Cause." This is the assumption that because one act, such as heroin use, has followed another, such as the use of marijuana, the earlier act is the cause of the later one. Any use of the fear approach must be based on valid information about hazards. To use the fear approach successfully, the material must fit the circumstances that children recognize as familiar, but not be so repulsive that reality is suppressed or denied.

EXHORTATORY METHODS AND MATERIALS. Based on findings in attitude research that sophisticated audiences are seldom persuaded by one-sided arguments, many articles, leaflets, lectures, and films are designed on the principle that the audience wants documentation for making decisions on drugs. One session conducted at Temple University included pre- and post measures of knowledge and attitudes as a test of the method.[5] In addition to the fact that knowledge increased for every type of group was the finding that the group's attitudes toward marijuana shifted from being relatively positive toward legalization to a more neutral position, especially among the undergraduates.

Exhortations are undoubtedly effective for those who are searching for new points or arguments. It is well recognized that not all information is equal in impact, but tends to be selected to fit previous positions. However, with large groups of students vacillating today about drugs, these pros and cons may often serve their intended purpose of providing a logical basis for decisions.

PROFESSIONAL OR EXPERIENTIAL AUTHORITY. This method of information transmission is often used in drug abuse education to convince audiences of the validity of the message. Since there is much public confusion about drugs today, there are many kinds of authorities asked for their expert opinion -- physicians, legal and enforcement officials, psychologists, sociologists, and ex-addicts. All authorities, however, are not seen as equal in usefulness. In a study in Michigan, high school students rated nine types of persons for their ability to advise on drugs.[6] Personal physicians and university "doctors" received the highest ratings, drug users were near the median, and policeman, ministers, and school counselors were at the lower end of the scale. The ratings seem to indicate that high school students want advice on the health aspects of drugs rather than on the moral or legal implications.

The use of former drug users or addicts in educational programs was exemplified in an experiment in classroom instruction and teacher training by four ex-heroin addicts in two junior high schools in the Boyle Heights section (predominantly Mexican-American) of Los Angeles, California.[7] Both experimental and control schools, which were included in the research design, conducted units of narcotics education, and students in both sets of schools scored approximately the same in a pre-test inventory of knowledge and attitudes. The statistical findings support the educational success of the project in that the experimental schools were strikingly higher than the control schools in drug knowledge at the end of the instruction period. The students in the experimental schools also differed on a number of attitude items indicating caution about drug use or desirable differentiation of ideas about drugs and drug users. Students interviewed at a later period mentioned the ex-addicts as the most worthwhile part of the unit; while teachers rated the ex-addicts as one of the better aspects of the special training given them in advance.

A potential hazard was noted in the observation that some students might have seen drug addiction as the means to a desirable end, since the addicts were healthy young adults acting in the prestigeful role of teacher. The most successful part of the ex-addicts' contribution, for both teachers and students, was their account of their own addictive histories. Apparently, the ex-addicts lent credibility to the subject that few teachers could have provided. The use of ex-addicts for "source credibility" is important as a new technique and may be one of the few successful methods for attitude change; however, according to Geis, needs to be used with caution.

INCREASED STATUS. One example of the principle that learning will occur when rewarded by increased status in a current role or a desired new one can be seen in the Coronado, California project in which students conduct searches for facts on drugs and drug use and, then, transmit the information to their peers as student-teachers.[8] This is assumed to have the same effect that many adults have experienced -- the motivation to learn increases with the responsibility of conveying the information to an audience.

The same principle operated in a continuing education project for pharmacists conducted by Columbia University.[9] Pharmacists enrolled in seminars on drug abuse and were trained at the same time to speak on the subject when requested by schools and community organizations.

CONCEPTS IN A LOGICAL STRUCTURE. This method of conveying drug abuse knowledge to students is based on the idea that students will achieve a new cognitive structure about drugs, that they will be able to draw on in making decisions or learning new concepts. The purpose of transmitting information in this form is not primarily persuasive, although most materials are created with the hope that students will favor moderation or abstinence. The Minnesota Mining & Manufacturing health

education sequence on mood-altering substances, as do many course guides and outlines fit this category.

A principle quite similar to concept attainment has been incorporated into a curriculum innovation in California, begun initially for use in an anti-smoking education program.[10] Fifth and sixth graders study the circulatory and respiratory systems with each unit including a segment on diseases and care of the system. The expectation is that students will attain the desired conclusions gradually but indelibly, after immersion in a many-faceted subject.

The use of the traditional outline or structural method undoubtedly increases understanding among "good" students who are highly motivated to absorb and retain facts. It appears from evaluations now completed that acquisition of factual knowledge is easily accomplished. According to Richards, however, one should not be overly optimistic about the effectiveness of the conceptual approach in changing attitudes or practices. A conceptual system linked to study of the body systems may prove to be more profound in its impact.

ENCOUNTER. This method is being used at both ends of what might be called a drug use continuum -- for prevention and for rehabilitation. The principle rests upon the belief that for many, attitudes toward drugs are closely related to one's feeling of identity and attitudes toward others and society. William P. Soskin recommends some of these group techniques (i.e., encounter, attitudinal confrontation, sensitivity training) as substitutes for functions that neither the school nor the home can no longer perform adequately.[11]

A dearth of commentary is available on the outcome of this method in educational settings as distinct from therapeutic ones. Although some would argue that it is difficult to distinguish between the two purposes, it would be enlightening, nevertheless, to learn the extent and duration of changes in specific attitudes toward drug use as a result of group techniques. One would suspect that not all persons' attitudes toward drugs are closely tied to the self-image and that less intense versions of the encounter method would suffice for many.

ENTERTAINMENT. Although it may not qualify strictly as an educational method, the addition of humor or entertainment techniques is fairly new to the drug abuse message. The Professional Arts Company has a film entitled: POT IS A PUT-ON that provides some comic relief from a steady stream of serious facts and opinion. Another piece of entertainment is THE UNDERGROUND BIRD, a play that can be performed by amateur groups, written for use by high school students. It is not humorous, but dramatizes the decision-making processes of a small group of searching young people (See Appendix E).

The preceeding are seven approaches in current drug abuse education activities. Although some of the approaches are traditional and some quite new, each has its own optimum utility in certain combinations of persons and settings. Knowledge of this "operant level" is essential for designing a successful approach. According to Richards, [12] considerations on how approaches might be chosen for different operant levels are: (1) the higher the intellectual development of a target group, the less likely it is that the fear approach, one-sided arguments, or authority will accomplish the purpose. Two-sided presentations, elaboration of concepts, or involvement of self seem more appropriate; (2) the greater the involvement with drugs by persons in a target group, the less likely it is that any approach will have an effect except involvement of self; (3) the innovative approaches may be less successful with younger and less educated persons, and those who are inexperienced in drug use; and (4) in addition to the level of intellectual development and the extent of involvement with drugs, age, social status, and attitudes of audiences are important to consider. Applying approacnes to specific characteristics of audiences, and being alert to the feedback, can take drug abuse education much farther than it is to date.

NATIONAL DRUG ABUSE PREVENTION PROGRAM.[13]

TEACHER TRAINING. The Office of Education will direct a $3.5 million program to train school personnel, particularly teachers, in the fundamentals of drug education. Grants, from $40,000 to $210,000, will be given to states on the basis of their populations. States will be encouraged to match their grant awards. Each state will be free to spend the money on training teachers as it sees fit. However, the Office of Education anticipates that most states will want to use the government's training centers that will be operated in key locations around the country.

A National Action Committee (See Appendix H) has been formed to provide leadership, technical assistance and aid in program planning, development, monitoring, and evaluation. The Committee sponsored a national conference in Chicago in April, 1970 to develop details of the program with representatives of all the states. During June, July and August of 1970, those states that wished to participate in the program sent teams of teachers, counselors, school administrators, students, and community leaders to be trained at selected university centers. The Office of Education estimated that three hundred persons received this intensive training. During fall, 1970 the state teams, who attended the Chicago conference, will tour their home states to train additional teachers, administrators, students and community leaders drawn from every local school district in the state. In all, these workshops will be attended by approximately 150,000 teachers and 75,000 students and community leaders. The people so trained will thus be capable of presenting the fundamental facts for a drug education program to every school district in the country.

Finally, in the spring of 1971, the National Action Committee will sponsor a series of regional conferences to evaluate the effectiveness of the program and plan next steps.

THE NATIONAL CLEARINGHOUSE FOR DRUG ABUSE INFORMATION. The National Clearinghouse for Drug Abuse Information has been created to give the public one central office to contact for assistance. The Clearinghouse will collect and disseminate materials and data taken from federal programs and appropriate private, state and local projects. The Clearinghouse will maintain a computer data bank on a wide variety of drug abuse programs that will enable the government to give much more detailed answers to queries than is possible under the present decentralized system. The Clearinghouse, operated by the Department of Health, Education and Welfare's National Institute of Mental Health for the Federal Government will become fully operational in September, 1970.

LAW ENFORCEMENT ASSISTANCE ADMINISTRATION DRUG PROGRAM. The Law Enforcement Assistance has made available up to $10 million to large cities in the United States for programs including drug education. Under Section 306 of the Omnibus Crime Control and Safe Streets Act of 1968, the Law Enforcement Assistance Administration may allocate in its discretion fifteen per cent of its total appropriation for action. For FY 1970, this amount is $32.5 million. Ten million of this has been set aside for 112 cities which can qualify for up to $250,000.

In addition, the Law Enforcement Assistance Administration has set aside another $350,000 for Metropolitan drug enforcement programs which must include educational expertise as a component part.

EXPANDED DRUG ABUSE PREVENTION ADVERTISING CAMPAIGN. In cooperation with the media, and the Advertising Council, Inc., the National Institute of Mental Health launched an all-media advertising program in April, 1969. Facts about the dangers of abusing drugs were the basis for a series of television and radio spot announcements, magazine and newspaper advertisements, outdoor billboards, transit cards, and posters.

Because of the importance of the problem of drug abuse, the Administration asked the Advertising Council to make a drug abuse program one of its major campaigns in 1970. The initial phase of the three-year program will be a preventive program aimed at elementary and junior high school students. Three Federal agencies (Department of Defense; Health, Education and Welfare; and Justice Department) have each allocated $50,000 annually to fund production costs for a wide range of new advertising messages.

INTENSIFIED PROFESSIONAL TRAINING IN PREVENTION AND TREATMENT OF DRUG ABUSE. The National Institute of Mental Health is accelerating its training activities in drug abuse prevention, treatment and rehabilitation with supplemental funding of $1 million in FY 1970. The Institute is establishing four major areas for intensive training activities: (1) Training of professional and paraprofessionals working or planning to work in the drug field; (2) Training of health and social service personnel to counsel drug abusers; (3) Preparation of innovative training materials for teachers; and (4) Development and dissemination of materials for practicing health professionals. Priority projects will include four-week training courses combining didactic and clinical training, to be held at four specialized training centers attached to community treatment facilities, for persons working in drug abuse treatment or rehabilitation. It is anticipated that this program will train seven hundred twenty persons at a cost of $500,000.

NATIONAL INSTITUTE OF MENTAL HEALTH MARIJUANA CONTRACT PROGRAM. The National Institute of Mental Health marijuana research program for FY 1970 will be accelerated as a result of supplemental funding in the amount of $1 million. The program, which will be developed through contracts, has four major objectives: (1) Ascertain the consequences of long-term use of marijuana in humans; (2) Determine the effects of marijuana on driving and other skilled acts; (3) Continue and accelerate studies to determine pharmacological properties of marijuana, its toxicity, and effects on biology and behavior of animals and humans; and (4) Continue and accelerate production and supply of marijuana in its various forms to competent investigators.

The Administration's new program to fight drug abuse is being directed by the Ad Hoc Committee on Drug Abuse, which is chaired by Charles B. (Bud) Wilkinson, Special Consultant to the President. The membership of the committee includes John E. Ingersoll, Director of the Bureau of Narcotics and Dangerous Drugs; Dr. Stanley F. Yolles, Director of the National Institute of Mental Health; and representatives of the Office of Economic Opportunity and the Departments of Defense; Health, Education and Welfare; and Labor. Funding for the overall program has increased from $66.5 million in FY 1969 to $105.8 million in FY 1970 and will increase to $135.6 million in FY 1971.

PROPOSED NATIONAL ADDICTION CORPS.[14]

In March, 1970 United States Representative Richard L. Ottinger introduced H.R. 16730, The Narcotics Education Act of 1970 that calls for the federal appropriation of $10 million in the first year for the creation of an addict prevention corps (APC). Members of the APC are to be made up of ex-addicts and other young people who would be sent into the nation's schools to teach about the evils of drugs and their abuse. APC members would also be available for counseling youngsters with drug problems and sponsoring

teen-age clubs to combat drug addiction. Ottinger also sees part of the appropriation being used for special audio-visual materials that would be used in conjunction with lectures made by APC members. He projects that as many as 4,000 to 5,000 ex-addicts and addiction specialists could be employed at an annual per capita expense of $20,000.

Ottinger has made his proposal on the basis that ex-addicts are better equipped to bridge the communications gap that may exist between youngsters and members of older generations. He contends that ex-addicts can communicate with youngsters at their own level and can best get the message across about the evils of drugs because they (the addicts) have been through the experiences and suffered the pains of addiction. Ottinger has made these conclusions after visiting a rehabilitation facility in New York City that includes, as part of its program for ex-addicts, the opportunity for the ex-addicts to speak to students in the New York City school system.

STATE ACTION AGAINST DRUG ABUSE.[15]

ALABAMA. Governor Albert Brewer sponsored a drug education program in February, 1970 for school administrators and other personnel in school systems throughout the state. A curriculum guide has been prepared for grades kindergarten-12 by the state department of education.

ALASKA. Governor Keith Miller appointed a statewide coordinator of drug abuse education. The coordinator's prime duties will be to communicate with and unify the aims and goals of community action groups throughout Alaska. The coordinator will help establish guidelines and curricula for the state's education program, legislative goals and special preventive and rehabilitative programs. Additionally, Alaska is participating in the United States Department of Health, Education and Welfare program wherein a team of six from Alaska will receive training at a national training center in drug education in the summer of 1970 and upon return will be fielded to produce a knowledgeable and functioning community. A pilot project co-sponsored by the state department of education and a local school district, utilizing Lockheed's drug decision program, is in final completion stages.

ARIZONA. During the 1969 legislative session, $30,000 was appropriated for narcotics education through the Arizona department of public safety. As a result, the state now has a full-time narcotics education officer and public information officer for the narcotics division. These men gather and distribute all information on narcotics control and drug abuse, with the main emphasis on educating teachers in order to disseminate information to students. The 1970 Arizona legislature is considering bills to more clearly define narcotics and drug control laws and to give law enforcement officers better tools to control the use of narcotics.

CALIFORNIA. Governor Ronald Reagon has proposed a comprehensive plan for intra-state control of the inventory, shipment and sale of restricted and dangerous drugs. He has recommended that the judicial council plan a training institute on narcotics and dangerous drugs for judges and probation officers. The governor has also proposed legislation to require physicians to dispose of unwanted sample drugs, used hypodermic needles, syringes and old drugs. A state office of narcotics and drug abuse coordination has been created by executive order to coordinate preventive and treatment programs. The governor has asked the state department of education to develop a comprehensive curriculum on health education which would begin in the first grade, in-service training for teachers of grades 1-12 and mandatory health training in drug abuse in college curriculum for future teachers.

The California Interagency Council on Drug Abuse, established in October, 1968 by the California Medical Association in cooperation with the State of California and the Parent-Teacher Association, is a clearinghouse for the exchange of information and techniques found useful in combating the state's drug abuse problem.

COLORADO. Governor John Love has signed legislation requiring prescriptions for all codeine-bearing substances. Other new bills appropriated $153,000 to the department of education and $100,000 to the department of health for the development of school and community education programs concerning alcoholism and drug abuse. A legislative resolution has placed responsibility for the planning and evaluation of alcohol and drug education programs in the continuing state interdepartmental committee.

CONNECTICUT. A governor's conference held in October, 1969 requested immediate action as well as a long range plan to be completed by June, 1971. A drug advisory council was formed including the departments of health, mental health, education and higher education. A recent teacher-training effort exposed 400 teachers to new concepts, ex-addicts and current curriculum developments.

DELAWARE. The state distributes educational pamphlets through all pharmacies; makes available upon request lists of qualified speakers and films on the subject of drug control; provides guidance to private organizations, schools and community organizations in obtaining drug control information. A bill which resulted from a study by the governor's drug control council has been approved by the Delaware House. It provides $265,000 for a comprehensive program, creates the position of drug control coordinator and a drug control unit within the department of health and social services, with responsibility for treatment, education and law enforcement. The bill includes funds for drug abuse clinics, the upgrading of equipment and increasing personnel in the state police narcotic unit and for introducing comprehensive curriculum in the schools.

FLORIDA. The governor's task force on narcotics, dangerous drugs and alcohol abuse has placed considerable emphasis on drug abuse education and prevention programs. Plans have been developed for a tele-lecture system, utilizing telephone lines, to transmit audio presentations to lecture halls and other gathering places for law enforcement personnel, education groups and others. The task force has also developed a media center in Tallahassee to forward resource materials to educators, corrections personnel, judges and others. Legislation has resulted in penalties becoming more stringent for drug use.

HAWAII. Governor John Burns has announced a state-wide drug education program. A new school health education program, developed by the state department of education and taught in kindergarten through grade 12, deals in part with a six week course sponsored by citizens councils on narcotics control. Legislation enacted in 1969 has made use of marijuana by first offenders a misdemeanor.

IDAHO. The Idaho Bureau of Drug Control, operating under the Idaho Board of Pharmacy, conducts an educational program as well as schools for law enforcement officers and is responsible for the drug law enforcement section of the annual Federal Bureau of Investigation Academy held at Idaho State University.

ILLINOIS. Violators of Illinois law, who are addicts and who are assigned by the court to report periodically during their parole or probationary period, are tested at the state's Nalline Testing Center to determine whether or not they have reverted to the use of drugs. The state further provides speakers and lecturers, along with display material and films, to various groups interested in drug control.

A drug abuse education program was initiated in the junior high and high schools throughout the state in the fall of 1969. Several films, display material, pamphlets and speakers are made available to the schools. Drug abuse information is to be included in regular school textbooks, geared to respective age levels. A training program for teachers in drug abuse education is being conducted by psychologists, psychiatrists, social workers, pharmacologists and law enforcement officers, and a bibliography for teachers has been compiled.

The state department of mental health has set up pilot programs using methadone centers for out-patient treatment of heroin addicts. Legislation would differentiate the penalties between the sale and possession of hallucinogenic drugs, making an illegal sale a felony. Legislation enacted in 1969 has made use of marijuana by first offenders a misdemeanor.

INDIANA. The state has developed a drug education program and the state police are training all recruits in drug control and offering drug abuse classes for local police departments.

IOWA. Programs in soft drug abuse are underway in several cities. Legislation passed in 1970 states that any youngster seeking drug abuse assistance from a community professional will not be prosecuted nor will his parents be informed without permission.

KANSAS. Governor Robert Docking has announced the first governor's drug abuse education seminar scheduled for late August. The governor's committee on criminal administration approved, at Docking's request, $40,000 in federal funds to help finance the August seminar and regional and local seminars in September and October.

KENTUCKY. Two aspects of the Kentucky educational program which have been cited as noteworthy by the National Institute of Mental Health are that: (1) Citizen groups themselves, not "state experts," are given the responsibility of establishing a dialogue between youth and adults in their communities; and (2) Members of the community are trained to act as community drug education leaders in bringing a closer understanding between youth and adults. Considerable emphasis is placed on the use of the educational materials, such as films and pamphlets, in the state's program, and all local groups receive interaction from young people.

The organizational framework of comprehensive care centers, operated by mental health-mental retardation boards throughout the state, is the key to the organization of training of regional drug education leaders and the effective implementation of county workshops and training seminars.

The Kentucky Board of Pharmacy and the drug information center at the University of Kentucky also are represented at all workshops and work with the education committees as well as the Bureau of Narcotics. At the present time funds are supplied through the regular budget of the Kentucky department of mental health. Six training sessions in 1969, and 14 in the first four months of 1970 have been held for drug education leaders. Televison, both commercial and the state educational television network, has been used in the state's campaign, with much more extensive use planned for 1970-1971.

A bill enacted by the 1970 legislature adds marijuana to the list of dangerous drugs and makes extensive changes in the handling of persoms convicted of dealing in or using dangerous drugs. Persons convicted of selling or distributing dangerous drugs may receive a maximum sentence of ten years or a fine of $10,000 or both. Possession of a dangerous drug for one's own use was made a misdemeanor rather than a felony, but only for the first and second offenses. Subsequent violations will be considered felonies.

LOUISIANA. The Louisiana Narcotics Rehabilitation Commission, which is charged with coordination and implementation of measures to control and prevent drug abuse, is planning a program to develop in-

patient facilities within the state for narcotic addicts and to expand the out-patient program. It also will seek funds from the legislature to develop a research center to study drug abuse and to implement an educational program.

MAINE. A state program funded for 1970 and operated primarily through the state drug abuse council will provide educational material on drug abuse, hospitals will be surveyed for the availability of services for drug users, a detoxification program, with possible American Association of General Practioners credits, will be offered to hospitals desiring it, and a 24 hour, seven-day emergency telephone service for those needing help on drug problems will be established. Teacher training workshops provide three hours of course credit for teachers of health sciences. Legislation raised penalties for drug use including marijuana. Local drug abuse councils have been established and educated. Additionally, Governor Curtis has established an interagency commission on drug abuse to coordinate all state governmental efforts dealing with the problems of drug abuse. In conjunction with this commission, the state health planning council is in the process of establishing a two-year plan for combatting drug abuse in Maine.

MARYLAND. The Maryland drug abuse authority, established in January, is charged with enhancing and developing programs in the areas of education, prevention, management and treatment and program plan and evaluation. The authority will take a non-punitive approach to the drug abuse problem.

MASSACHUSETTS. Massachusetts has a three-fold drug education program: The department of education has a program of guidelines available to all school systems. The office of the attorney general has a program of education available to police officials, community health officers and educators. The drug addiction rehabilitation board has been conducting an educational program aimed at professional and educational groups, has acted as consultant for educational workshops and has conducted seminars for doctors, guidance counselors, probation and parole officers.

Legislation proposed in 1970 would provide for the care of drug dependent persons by the department of mental health at regional community mental health centers, establish drug education courses in public schools from kindergarten through grade 12 and begin institutional experimentation and research into drugs. Being present where narcotics are used would no longer be a crime. Other proposals would authorize the arrest of certain possessors of harmful drugs without a warrant, permit the immediate examination and treatment of addicted minors without parental consent and consider the possession of three or more ounces of a narcotic as prima facie evidence of intent to sell.

Legislation passed in 1969 permits judges to refer drug users to treatment centers rather than prison.

MICHIGAN. The Michigan legislature has enacted legislation creating a critical health problems education program in the department of education. The program is designed to educate young people in the state's schools, both elementary and secondary, to the problems associated with drugs, alcohol, tobacco, mental health, etc. The bill also provides for special inservice and preservice training programs for professional preparation in health education for teachers throughout the state. The department of education establishes guidelines to assist local school districts in developing detailed health education programs, with funds to finance the program appropriated from the state's general fund.

Governor William Milliken has recommended an extensive drug control program which includes a coordinated educational and public information program, appointment of a drug-control counselor in every county in the state, and greater coordination of state, federal and private efforts in drug control. An office of drug abuse has been created in the governor's office to coordinate the state's attack on the drug problem.

MINNESOTA. The 1969 session of the Minnesota legislature appropriated $40,000 to the governor's office to establsih a program related to counseling, education and advice regarding drug abuse and addiction. Governor LeVander has appointed a special assistant for drug abuse education to coordinate existing programs, to plan a more comprehensive program for future implementations and to encourage and/or sponsor informational programs for potential drug abusers (especially among school-age children) and also for persons who have occasion to lead or educate young people.

MONTANA. The governor's crime control commission has allocated funds for public education on narcotics. The alcohol and drug dependence commission, created by the state legislature, is charged with coordinating all efforts within the state toward prevention, control and education programs on drug abuse. The office of the superintendent of public instruction is beginning a school personnel training program conducted by an interagency consortium which also includes the state department of health, the state alcohol and drug dependence commission, the governor's crime control commission. This state team will train other teams in drug education training. A curriculum guide for teachers on drugs and alcohol is being prepared under ESEA, Title III for state distribution; materials are also being readied on counseling students involved with drugs and listing sources of information on drugs. The Montana state board of health has guides available on alcohol and drug usage as well as educational films.

NEBRASKA. Nebraska's program of state-initiated drug education is carried out by the department of education at the University of Nebraska extension division and the Nebraska State Patrol which have films and literature available to public schools upon request. A team from the department of health presents a mandatory program on drug abuse to convicted youth in jail throughout the state.

Governor Tiemann organized a March, 1970 conference on drug abuse. The conference improved communication among all groups working in the drug abuse area and involved young people in the fight. A governor's commission on drug abuse was established in May, 1970 consisting of 12 citizens to join interested and professional people of the state of Nebraska with special interest and knowledge in the problems surrounding the illicit use of drugs within the state. They are charged with collecting information surrounding this problem, disseminating such information, developing solutions to the drug problem and coordinating the overall state effort of drug control for addict rehabilitation.

NEVADA. The education officer of the narcotics division promotes public-school level education to the dangers of drugs by encouraging schools to add drug abuse courses to their curricula. Legislation has resulted in penalties becoming more stringent for drug use.

NEW HAMPSHIRE. The state has entered into a cooperative agreement with the Regional Center for Education Training to offer a special teacher-training course in health education, strongly emphasizing drug education. The state also assists drug abuse programs at the community level. Legislation makes possession of more than one pound of marijuana a felony rather than a misdemeanor.

NEW JERSEY. Governor Cahill signed legislation in June, 1970 establishing a program to train teachers to teach about drug abuse and to develop a standard New Jersey curriculum. The particulars of the program are outlined in the legislation which states, in part:

> The workshops and training programs shall be under the direction of such persons as the commissioner may designate and shall include representatives from the Department of Education, the Department of Higher Education, Rutgers University, the New Jersey College of Medicine and Dentistry and the Urban Schools Development Council, or their successors, who shall constitute a sterring committee.[16]

The education measure directs every New Jersey school district to incorporate drug education into its health education curriculum by January 15, 1971. Ten hours of such instruction will be required in grades seven throught twelve during the school year. It is anticipated that some districts may want to start instruction in

the fifth grade.

The legislation directs the education department to establish summer workshops for a select group of teachers, perhaps 250 from 250 of the state's 587 school districts. For three weeks they will be instructed in how to teach other teachers to teach drug abuse, and the workshops also will be used to develop the curriculum.

The bill directs the education department to establish training programs for other teachers to be operated from September 15, through December 15, 1970. Teachers will attend 90 minute sessions over an eight week period, conducted by the 250 training teachers. The bill stipulates that the teachers will attend during the working day after having completed four hours of their normal schedule. A companion measure,[17] appropiates $175,000 to finance the training program, including stipends to the 250 training teachers and to develop curriculum and instructional materials.

Receipt of a grant from the federal government totaling $81,164 will allow the state to expand these efforts to include the elementary grades.

The governor also approved appropriations bills totaling $900,000 to expand the State Police enforcement program and to set up a training program for local police in narcotics control. Under provisions established by the legislation.[18] Fifty new state troopers will be hired for $800,000 to develop a special strike force aimed at major drug wholesalers and pushers and set up a network of regional State Police enforcement units. Additional legislation[19] provides $100,000 for the training of municipal police officers.

In addition to $1,075,000 appropriated to date, an additional $130,000 has been recently appropriated to expand the state's experimental program in methadone maintenance of heroin addicts. This appropriation, together with $190,000 in federal funds, is designed to treat an additional 250 addicts. The state is presently treating approximately 50 in this fashion.

The governor recently signed a $500,000 appropriation bill[20] to be interfaced with $900,000 in federal aid for continuing and expanding treatment and after-care centers in three New Jersey counties. This measure is actually not part of the governor's program, which will provide $400,000 for a network of clinics in north, central, and south Jersey and anticipates the takeover of present state-funded county clinics.

The other bills[21] signed by the governor would lift the ban on giving county and municipal jobs to persons once convicted of a high misdemeaner. A number of county clinics want to hire ex-addicts but are prohibited from doing so. The new law stipulates that the local

government and the Civil Service Commission must find that the prospective employe has been sufficiently rehabilitated.

The Cahill administration will seek legislative approval in September, 1970, of the rest of its program, including another $1.3 million in appropiations and revisions in some of the penalty laws. Still on the governor's agenda is a $225,000 appropriation for operational grants to the state's local school districts.

NEW MEXICO. A governor's advisory committee on narcotics addiction and drug abuse has been appointed. The committee will investigate the areas of narcotics and drug abuse, make recommendations for legislation and explore public education in these areas.

State law requires the board of education to prescribe course instruction on drug abuse from grades 7-12. Funding was only available for grade seven in 1970-71 school year.

The mental health section, health and social services department, has been authorized to provide drug education programs upon request. The funding level has not permitted it to be undertaken on a wide-range, scheduled basis.

NEW YORK. Governor Rockefeller outlined and signed in May legislation embodying a broad anti-narcotics program: $65 million for state aid to local government agencies for operating drug abuse treatment programs; authorization for local governmental agencies to provide such services directly or by contract with qualified voluntary agencies; authorization for the Health and Mental Hygiene Facilities Improvement Corporation to construct, acquire or rehabilitate facilities for use by local agencies in the conduct of drug abuse treatment programs; and authorization for the state housing finance agency to issue an additional $200 million in notes and bonds to finance the construction, acquisition or rehabilitation of such facilities by the governor. $15 million requested to provide methadone treatment for heroin addicts has been approved.

In addition the division for youth is authorized to establish and operate residential youth development programs to which any youthful addict or drug abuser under the age of eleven may be admitted; and the director of in-take for the division of youth is himself authorized to refer youths to division facilities.

1970 legislation is intended to encourage local governments, acting directly or through qualified voluntary agencies, to call upon and utilize the proven skills and resources of the state agencies in developing new and improved programs to provide both in-patient and out-patient care to these children. The state will provide financial support of up to 50 percent of the full operating costs to local programs, while giving localities the maximum flexibility to tailor

their programs to local needs.

The narcotic addiction control commission sponsors public education programs and operates 16 community narcotic education centers across the state.

NORTH CAROLINA. The 1969 North Carolina General Assembly authorized an 11-member legislative study commission on the use of illegal and harmful drugs. Governor Robert Scott named his seven appointees to the commission in January, 1970. Several thousand persons of all age groups attended a governor's conference on drug abuse held in Raleigh, April 15. Regional seminars across the state to identify problems and suggest solutions followed the conference.

The study commission, divided into three subcommittees on enforcement, education and treatment, and rehabilitation, will work closely with the North Carolina department of public instruction in presenting three drug abuse workshops for teachers. Sixty teachers will be enrolled at each of the two-week workshops. These teachers will conduct similar in-service training in their local school systems in the fall of 1970. The study commission will also be involved in three workshops sponsored by East Carolina University at Greenville for teachers in eastern North Carolina. All of the workshops will cover drug terminology, psychological and physicological aspects of drug use, pharmacology, legal aspects, the drug subculture and community problems.

The department of public instruction is adjusting its curriculum concerned with drug abuse information to reflect the increased knowledge the workshops will provide.

At Governor Scott's request, state agencies concerned with the drug abuse problem are coordinating their efforts with study commission efforts.

On May 28, Governor Scott announced the creation of a statewide drug "cool line," intended to provide facts about drugs and their use.

NORTH DAKOTA. Conference recommendations are now under consideration by Governor William Guy. North Dakota State University's extension division has planned a series of drug control workshops to be held throughout the state.

OHIO. Ohio state superintendent of schools, Martin W. Essex, has announced that a new drug education curriculum, which can be incorporated in traditional health and science classes, is expected to be available to all Ohio school districts in September, 1970. By September, 1971, a complete curriculum, which covers grades 4 to 12, inclusive, is scheduled for distribution to Ohio schools. Staff members within the department are also developing a guide to

drug education for school personnel. In addition, the Ohio department of education is actively engaged in establishing a massive drug education training service for Ohio educators and lay persons. Present plans include a state training team which will be available to school districts for the purpose of acquainting teachers and school administrators with the most recent methods, techniques and materials in drug education.

The legislature is considering an omnibus drug control bill which would reclassify marijuana as a hallucinogen subject to misdemeanor rather than felony penalties and establish a state drug rehabilitation program for youth offenders. Doctors treating youths 16 years of age or older for drug problems would not be obligated to notify parents. A first offender of drug laws would undergo psychiatric testing and could be ordered by the court to undergo rehabilitation for six months to two years in a state hospital or community clinic or under private care.

OKLAHOMA. Governor Dewey Bartlett has asked the legislature to form a committee to study possible revision of state drug laws. The governor has established a drug abuse council with a full-time director to study, research and coordinate drug control efforts.

OREGON. Governor Tom McCall has initiated the "Oregon Drug Alert," which is a concentrated, state-wide program to marshall drug information and develop local initiative in controlling drug abuse. As part of the program, Governor McCall interviewed a number of administrators and citizens regarding the drug problem over an internal televised hook-up reaching five different regional meetings. As a result, the state is now correlating regional reports and recommendations, developing statistical material and establishing a base for further state drug control action.

PENNSYLVANIA. A K-12 curriculum has been developed by the department of education to teach school children about drug use. Approximately 50 one-day seminars have been designed by the division of drug control in the department of health to help prevent drug abuse by giving school and college administrators and teachers factual information.

Proposed legislation would provide for comprehensive programs for the treatment and rehabilitation of drug dependent persons, create a central registry requiring the reporting of drug dependent persons and provide for a triplicate prescription procedure for drugs.

RHODE ISLAND. Governor Frank Licht has created a narcotics squad within the detective division of the state police to investigate and apprehend individuals engaged in the illicit distribution and trading of narcotics. A drug prevention unit is being established in the department of social and rehabilitative services. A 15-member advisory counsil on drug abuse control has been named to advise the

governor and general assembly on the care and rehabilitation of persons who are, or have been, addicted to narcotics or dangerous drugs and those in imminent danger of being addicted. A civil commitment law permits the courts to commit addicts for treatment on a civil rather than a criminal basis.

The state has established a residential treatment facility and an urban day care center for addicts, which will function as a hospital out-patient clinic, a referral agency will provide after-care services such as job counseling and vocational training. Assistance in any drug-related crisis is offered through 24-hour phone service.

A curriculum and resource guide has been developed by the state department of education. Specialized training was offered to teachers to help them understand the role they play in dealing with the narcotics problem. In 1969, Rhode Island undertook a statewide campaign to educate youngsters in public schools to the dangers of drugs, largely directed by young teenagers.

SOUTH CAROLINA. The South Carolina legislature in 1970 appropriated $100,000 for the planning of an alcohol and drug addiction treatment center. The governor's committee on mental health and mental retardation has recommended development of a comprehensive education program with various state agencies and the University of South Carolina involved in the planning. The committee has also recommended reducing the charge for marijuana use from a felony to a misdemeanor and strengthening penalties for drug pushers. A comprehensive plan defining the roles of state agencies involved in drug abuse programs, including education, treatment and rehabilitation, is being drafted.

SOUTH DAKOTA. The state is in the process of setting up a new and separate department of drug abuse with both educational and police functions.

A comprehensive revision of the state's drugs and narcotics law was enacted by the 1970 legislature following a State Supreme Court ruling nullifying much of the former law.

Other measures which were considered by the 1970 legislature include: an implied consent law to search vehicles when a law enforcement officer has reasons to believe a drug law is being violated; county-district judges to commit persons under the influence of drugs to the state hospital for psychiatric evaluation and treatment; state, counties and municipalities to appropriate a special fund for narcotics buys and to permit the names of the agents to remain confidential; a bill to permit arrest of persons who knowingly habit a room or building where drugs are used or stored; legislation to require imprisonment in the penitentiary, rather than county jails, for conviction of a felony related to narcotics. A statewide educational

plan for grades K-12 is just being completed and is expected to be implemented in September, 1970.

TENNESSEE. Governor Buford Ellington sponsored a conference on drug abuse and drug dependence in March, 1970.

The Tennessee department of mental health has been designated as the responsible agency for developing a broad-based drug abuse education program.

TEXAS. More than a half million leaflets have been distributed to acquaint teenagers with laws dealing with drug abuse. The legislature authorized a three-fold increase in state anti-narcotics officers in the department of public safety. The first criminal justice plan for Texas will deal with a number of problems, including drug abuse.

Committees are conducting studies into the availability and use of drugs and narcotics traffic and resulting crime in the state, as well as state rehabilitation programs. The state also has two important measures up for funding in Fiscal year 1970. One would create a multi-county or regional treatment center for drug abuse patients. The other would establish a drug control training program with accredited colleges and universities. The program would be conducted on a short-course basis, primarily for school teachers and law enforcement officals.

Beginning in September, 1970, Texas will have a drug education program for all students from grades five through 12 in every rural school district in the state. The program will be under the supervision and direction of the central education agency, which is developing curricula and teaching materials with the assistance of the crime and narcotics advisory commission. Course guidelines will be prepared in cooperation with the Texas Medical Association, State Bar of Texas, Texas Pharmaceutical Association, and the Department of Public Safety.

UTAH. The governor's citizen advisory committee on drugs has recommended establishment of a division on drugs which would research, investigate and develop training programs for informing the public and also implement a statewide educational program against drug abuse. The division would consult with the state board of education and state course of study committee. The citizen committee recommended that all drug control legislation be brought under the administration of the division of drugs and combined into one specific statute under the penal code. The division would also have jurisdiction over a proposed rehabilitation program for drug users.

VERMONT. By executive order, Governor Deane Davis has created a drug council as a part of the governor's commission on crime control and prevention to coordinate efforts against drug abuse.

New programs being initiated by the state include: a crime laboratory equipped to quickly analyze drugs; a new educational program beginning at the kindergarten level; community programs in at least one test area to educate the public and parents. New approaches for drug use prevention and control are being investigated by the department of mental health.

WASHINGTON. Governor Daniel Evans appointed a drug abuse task force and made an emergency allocation of $40,200 to the superintendent of public instruction in January, 1970 to design and implement a model state drug abuse education program. A statewide drug control unit has been established to work under the state patrol. Legislation (1969) made use of marijuana by first offenders a misdemeanor.

WISCONSIN. Legislation enacted in Wisconsin in February, 1970 lessened the penalties for users of marijuana, increased the penalties for pushers, and created a dangerous substance control council within the justice department. Legislation has also created a drug abuse control commission, charied by the governor and comprised of major state agency heads, health and social services, justice and public instruction, and four state legislators, to act as a high level coordinating council. A statewide governor's conference on drugs and alcohol with delegates appointed from all counties and major communities was held in June, 1970.

WYOMING. The department of education will sponsor a ten-day drug abuse education conference for sixty teachers, counselors and administrators. Students will be involved in a major portion of the conference. The state department is also planning a drug abuse curriculum. A pilot program has been offered in the Cheyenne public schools and after revision will be implemented fully for grades 5-9. Governor Hathaway's advisory council has called for cooperation between the state department of health and social services and the Wyoming mental health centers in providing treatment.

VIRGIN ISLANDS. The islands have a broad drug education program that includes use of radio programs, leaflets, and films. The state course of study committee is working on programs for schools, and law enforcement agencies are conducting programs for private organizations.

EXEMPLARY DRUG CURRICULA.[22]

As indicated earlier, the Nixon Administration's new program to fight drug abuse is being directed by an Ad Hoc Committee on Drug Abuse, which is chaired by Charles B. (Bud) Wilkinson, Special Consultant to the President. The objectives of the Committee are four-fold: (1) to improve existing programs and materials on drug abuse; (2) to improve methods of making material on drug abuse available to the public; (3) to improve coordination of efforts of departments and agencies concerned with drug abuse;

and (4) to improve upon and seek new ways concerned groups of citizens can fight drug abuse.

As an initial step, the Committee will make available to the nation's schools a variety of state and local curricula for drug education and the prevention of drug abuse, and has established an interdisciplinary panel of non-government professionals to review some of the drug abuse curricula developed by state and local school systems.

The curricula selected are not recommended for adoption, but are distributed only as resources to assist schools in initiating or improving programs. The first curricula selected for the National Clearinghouse on Drug Abuse Information Curricula Series are:

Baltimore County Board of Education
Towson, Maryland - Grades 6, 9, 12

Flagstaff Public Schools
Flagstaff, Arizona - Grades K-12

Great Falls School District No. 1
Great Falls, Montana - Grade 6

New York State Education Department
Albany, New York - Grades 4, 5, 6

Rhode Island Department of Education
Providence, Rhode Island - Grades K-12

San Francisco Unified School District
San Francisco, California - Grades K-12

South Bay Union School District
Imperial Beach, California - Grades K-12

Tacoma Public Schools
Tacoma, Washington - Grades 6-12

Address of the Clearinghouse is: National Clearinghouse for Drug Abuse Information, 5454 Wisconsin Avenue, Chevy Chase, Maryland 20015.

LOCAL SCHOOL BOARD RESPONSIBILITY.[23]

The very nature of their role makes local school boards responsible for maintaining and administering a school system and improving curricula. According to David H. Kurtzman, Secretary of Education in Pennsylvania since 1967, boards of education must build their own background of understanding on what schools can offer in drug education programs; enlist the assistance of professional educators, law enforcement agencies, medical and social agencies and the general public; and must assume the major

responsibility for changing student attitudes toward drugs. Writing in the June issue of Compact, Kurtzman proposed a ten-point program, not necessarily in priority ranking, to achieve the above-stated objectives:

1) Schedule special board meetings to discuss drug matters;

2) Ask the school superintendent to have his staff present at school board meetings on health curriculum stressing drug education;

3) Identify and recruit qualified, competent teachers to carry out drug programs effectively;

4) Review the literature on drug abuse in order to be informed on the subject;

5) Attend district, state, regional and national meetings where drug curriculum problems will be discussed and ideas exchanged;

6) Enlist consultants who can meet with the board of education to explain innovative teaching strategies in health education;

7) Secure advice and assistance from the community in planning drug education programs;

8) Establish policy on disciplinary measures for students found selling or using drugs on school grounds;

9) Provide money, space, and most important, the time to develop and pursue drug education programs; and

10) Encourage staff and students to participate creatively in innovative approaches to drug education.

In the final analysis, local school boards alone cannot eliminate the drug hazard. What is needed is a concerted attack that enlists the cooperation of the school, the parents, and the community at large. Local school boards can, however, play a role in the drawing together of these various elements and at the same time provide the leadership necessary for finding viable solutions to the problem.

FOOTNOTES

[1]Louise G. Richards, "Government Programs and Psychological Principles in Drug Abuse Education," Paper presented at the American Psychological Association Convention, Washington, D.C., August 31-September 4, 1969, p. 5.

[2]Gilbert Geis and Edward Morgan, "Education Regarding Abuse of Narcotics and Dangerous Drugs," Unpublished Research Prospectus, Southern California Research Institute, Los Angeles, California, September 1, 1967, p. 13.

[3]Richards, op. cit., p. 8.

[4]Irving L. Janis and Seymour Feshback, "Effects of Fear-Arousing Communications," Journal of Abnormal and Social Psychology," XLVIII, (1953), pp. 247-252.

[5]John D. Swisher and Richard E. Horman, "Evaluation of Temple University's Drug Abuse Prevention Program," Unpublished Report, Philadelphia, Temple University, (September, 1968), p. 33.

[6]Richard A. Bogg, Roy G. Smith and Susan D. Russell, "Drugs and Michigan High School Students, Special House Committee on Narcotics, Michigan House of Representatives, (Lansing, Michigan, 1968).

[7]Gilbert Geis (et. al.), "Addicts in the Classroom: The Impact of an Experimental Narcotics Program on Junior High School Pupils," Unpublished Report, U.S. Office of Economic Opportunity, Washington, D.C., 1969.

[8]Clifford W. Jordon, "A Drug Abuse Project," The Journal of School Health, XXXVIII, No. 10 (December, 1968), pp. 693-695.

[9]Jack E. Gross, Bureau of Narcotics and Dangerous Drugs, Respect for Drugs, (Washington, D.C.: Government Printing Office, 1968).

[10]Roy L. Davis, "Status of Smoking Education Research," Journal of School Health, XXXVIII, No. 6 (June, 1968), pp. 323-332.

[11]William P. Soskin's remarks as a participant in the symposium, "Drugs and Hippies: Education, Counseling, and Therapeutic Strategies," at the Annual Convention of the American Psychological Association, 1968.

[12]Richards, op. cit.

[13]Office of the White House Press Secretary, Statement by the President of the United States, Richard M. Nixon, "Drug Abuse Program Fact Sheet," (March, 11, 1970), pp. 1-5.
"Drugs in the Schools," Compact, IV, No. 3 (June, 1970), p. 25.

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[14]"Drugs in the Schools," Compact, op. cit., p. 39.

[15]Ibid., pp. 28-33.

[16]State of New Jersey, Referred to Committee on Law, Public Safety, and Defense, Assembly No. 1056, Introduced May 4, 1970, by Assemblymen Russo, Ewing, Woodson, Owens, (et. al.).

[17]_____, Referred to Committee on Law, Public Safety, and Defense, Assembly No. 1061, Introduced May 4, 1970, by Assemblymen Costa, Circio, Smith, Ewing, (et. al.).

[18]_____, Referred to Committee on Appropriations, Assembly No. 1052, Introduced May 4, 1970, by Assemblymen Dennis, Wilson, Kaltenbacher, (et. al.).

[19]_____, Referred to Committee on Law, Public Safety, and Defense, Assembly No. 1051, Introduced May 4, 1970, by Assemblymen Dennis, Wilson, Kaltenbacher, (et. al).

[20]_____, Referred to Committee on Law, Public Safety, and Defense, Assembly No. 1062, Introduced May 4, 1970, by Assemblyman Dickey.

[21]_____, Referred to Committee on County and Municipal Government, Assembly No. 816 and 817, Introduced March 16, 1970, by Assemblymen Dennis, Kaltenbacher and Wilson.

[22]"Drugs in the Schools," Compact, op. cit., p. 11.

[23]David H. Kurtzman, "Leadership By Local School Boards," Compact, IV, No. 3 (June, 1970), pp. 34-35.

TREATMENT OF DRUG ADDICTION

This chapter is divided into two sections: Section one presents a review of the facilities and programs currently available for the treatment of drug addicts on the federal, state, and local level that are supported by public funds, and the treatment efforts of private, non-publically supported agencies. In section two, attention is focused on the various treatment methods that have been developed in recent years--the use of synthetic drugs such as methadone, the creation of sub-community settings like Synanon and Daytop Village, and other treatment modalities.

The question of treatment of drug addiction in the United States has been the subject of much concern in recent years. As a consequence, advances in the treatment of drug addiction are reflected, on the federal, state, and local levels, in the number and nature of treatment facilities available to attend to addicts and a proliferation in the number of treatment programs that have been developed at the various facilities and apart from them. The basic attitudes toward the problem of drug addiction have been essentially punitive in nature; however, there appears to be a growing acceptance of the school of thought that drug addiction is a process in a continuum of problems rather than a singular problem.

TREATMENT: FACILITIES AND PROGRAMS.

FEDERAL TREATMENT FACILITIES AND PROGRAMS. For over thirty years the United States Public Health Service has addressed itself to the problem of drug addiction. Hospitals were established at Lexington, Kentucky in 1935 and Fort Worth, Texas in 1938 primarily for the treatment of federal prisoners. The hospitals have had what is called a "voluntary treatment" program, whereby a patient could request treatment but withdraw from the program whenever the patient felt he was cured. The request for withdrawal usually came after the patient had gone through a short period of detoxification and he began to feel recovered from his experience. Readmission by the same patients over and over again was very common and the effort was sometimes called the "revolving door program."[1] An evaluation of this phenomenon and the realization that persons admitted to the program were not really being helped has led to the conclusion that breaking of the drug addiction habit is far more complex than mere detoxification. It is not enough to have a patient withdraw from the use of drugs for a period of ten to fourteen days and break the habit temporarily.

Only a small percentage of the total federal prisoner addict population was at any given time selected for commitment to Lexington or Fort Worth. Most federal prisoner addicts were committed to one of twenty-seven federal correctional institutions for the following reasons: failure of the staff to recognize the addiction; refusal of treatment by an inmate; and ineligibility based on security restrictions related to the nature of the offense or to prior criminal record. Inmates deemed insufficiently motivated for treatment were excluded.[2]

PASSAGE OF NARCOTIC ADDICT REHABILITATION ACT: In general, there was no program (either for evaluation and/or treatment) for federal addict prisoners committed to one of the Bureau of Prison's institutions. Therefore, no specialized program for narcotics addiction existed in the federal correctional system prior to the implementation of the Narcotic Addict Rehabilitation Act (NARA) of 1966.[3] Following passage of NARA, responsibility for the evaluation and treatment of selected narcotic addicts convicted of federal offenses was delegated to the Office of the Attorney General.[4] The Bureau of Prisons of the Depart-

ment of Justice has been charged with the responsibility for implementing the Act and developing the necessary programs.

Presently, three federal institutions, each designed to accommodate a maximum treatment population of 100-150 persons are accepting addicts for treatment: The Federal Correctional Institutions at Danbury, Connecticut; Terminal Island, California; and the Federal Reformitory for Women at Alderson, West Virginia.

The NARA enables states and communities to gradually assume responsibility for addicts. Under provisions of the Act, there exists a system of civil committment by the courts instead of the "leave-when-you-please" provisions of previous legislation, and a new element of carefully supervised after-care for a period of three years. Typically, in a Public Health Service Hospital the time-span for the overall program is: evaluation of approximately thirty days duration, followed by six minths in-patient care; and thirty-six months of carefully supervised care in the patient's own community.

Admission to the program is delineated in three basic provisions of the legislation -- Title I, Title II, and Title III. Under Title I, admission may be granted for those persons who are addicts and who have also violated certain federal legislation. A federal judge, with certain exceptions, may give an offender the opportunity to elect commitment to the Surgeon General of the Public Health Service for treatment and rehabilitation in lieu of prosecution and trial for the offense committed. If the treatment and rehabilitation is not successful, the offender is still leable for prosecution for the violation of the law that originally brought him before the court.

Under provisions of Title II of the Act, drug addicts who have already been convicted of a federal offense may be admitted to the program. A federal judge may commit the addict to treatment rather than punishment. Federal prisons receive these persons and their rehabilitation and treatment is administered by the Attorney General of the United States within the Bureau of Prisons. Title II also provides for follow up aftercare in the community upon the individuals release.

Title III of the Act allows for voluntary admission to the NARA treatment and rehabilitation program. Under this provision, an addict may petition a United States Attorney General for treatment and rehabilitation. If accepted and committed by the federal court, the individual is obligated to the regulatory forty-two month program and cannot withdraw voluntarily.

Certain persons are not eligible for treatment and rehabilitation under the provisions of the NARA. These persons include: (1) those charged with a crime of violence; (2) those charged with unlawfully importing, selling, or conspiring to import or sell a narcotic drug unless such sale was for the primary purpose of enabling the offender

to obtain a narcotic drug, for his personal use, because of his addiction to such a drug; (3) those against whom there is pending a prior change of a felony which has not been finally determined; (4) those who have been convicted of a felony on two or more prior occasions; and (5) those who have been civilly committed under the Act because of narcotic addiction on three or more occasions.[5] These exclusionary criteria may prove to be too stringent for committment under Titles I and II of the NARA. As an example, assult with a dangerous weapon or with the intent to commit any offense punishable by imprisonment for more than a year is reason for exclusion. Another reason for exclusion is conviction for burglary or housebreaking, in the nighttime, which is a common addict offense, as it provides a means of support for an addict's habit.

Previous mention was made of the treatment process implemented under provisions of NARA. However, at this juncture, it would appear to be advantageous to examine the process in greater detail. Evaluation and examination is the first phase of the process with a duration usually of approximately thirty days and is currently conducted at either the Lexington, Kentucky or Fort Worth, Texas facility. Withdrawal or detoxification is usually accomplished during the examination and evaluation period. Supplementary services are provided to the individual during this process and include studies by the medical, psychiatric, social and other services of the hospital.

During the six-month treatment process the individualized in-patient treatment is emphasized within a drug-free environment maintained under minimum security provisions. Psychiatric treatment, group therapy and other forms of patient participation in therapy (e.g., Narcotics Anonymous) are employed. A physical restoration program is implemented wherein the patient receives any dental, surgical and physical rehabilitative efforts necessary to overcome the effects of his drug addiction. During the latter stages of the six-month in-hospital treatment process, communication is established between the hospital and those community agencies that will continue the rehabilitation process in the patient's own community.

The National Institute of Mental Health executes the community after-care program under contracts with community agencies. For the most part, mental health centers are utilized to perform the community after-care phase of the treatment and rehabilitation program. Rehabilitation of the addict is the foremost objective and any service that may be available in the community to meet this objective is utilized. Temporary housing, continued group therapy, and social services are furnished. In addition, vocational counseling, placement services, and agencies skilled in domestic rehabilitation programs are provided as needed.

A rehabilitation plan for the three-year period is designed by a counselor in concert with the patient. If, during the course of

treatment and rehabilitation, the patient returns to the use of drugs various options are available: the individual may receive emergency treatment at a hospital in the community, he may be returned to the federal facility for further treatment, or in extreme cases the court may be requested to dismiss the individual from the program.

Those who work in the program established under provisions of the NARA realize that many questions need to be resolved in the treatment of drug addiction. Principles and practices that have worked successfully with other disability groups are being applied to the problems of drug addiction. Careful evaluation is being conducted of each phase of the problem with the hope that important experience and knowledge will be gained. In this way, modifications can be made to insure that the estimated 6,000 patients who will be involved in the program by 1973 will receive the most advanced and programmatic treatment and rehabilitation methods available.[6]

STATE TREATMENT FACILITIES AND PROGRAMS.

State efforts to combat the problems of drug addiction in the form of treatment programs have increased throughout the nation as attention and concern has become paramount. Four states, in particular, have developed treatment programs that have been the result of a high rate of incidence of drug use. This section will review the developments in California, Illinois, New Jersey, and New York -- the locales of the largest narcotic treatment control efforts.[7]

NEW YORK. New York State has initiated a highly comprehensive addiction treatment program. The program has been based upon experience with previous programs within the state and on the efforts of other states throughout the nation.

Treatment for addiction was infrequent before 1952. Resources for voluntary treatment were non-existent with the exemption of emergency hospital care in a small number of cases. During the three year period 1953 to 1956, individuals could voluntarily commit themselves to the hospital ward of the New York City Penitentiary. Treatment consisted primarily of withdrawal and the average patient stay was two weeks.[8]

The State Department of Correction assumed the responsibility of institutionalized care for addicts because no hospital facilities were available. Legislation within the State had permitted the commitment of individuals to hospitals for treatment but the procedures were not implemented.[9]

The State initiated, in 1956, a Special Narcotic Project in response to the increase in the number of parolees with a history of opiate addiction. Attempts to modify family and addict attitudes were carried out by the assignment of small caseloads and frequent home visits. In addition, close supervision was utilized to keep the

addict drug-free in the community. Other elements that were stressed included: continued and productive employment, development of vocational skills and constructive use of leisure time. Studies completed in 1960 and 1963 revealed that dramatic results were being accomplished through the efforts of the Project.[10] Treatment, however, was still not available before criminal involvement and then it was provided in a correctional institution.

In 1962, the Metclaf-Volker Act, placed responsibility for the care of arrested addicts with the state's Mental Hygiene Department's hospitals.[11] The Act called for a period of hospitalization not to exceed three years. An addict, when charged with a drug or non-drug crime, could elect treatment in one of the state's hospital facilities. Medical personnel made decisions regarding the after-care program and if the addict completed the program to the satisfaction of the physicains the criminal charge was dropped.

Insufficient funding, a lack of facilities, and a shortage of trained personnel led to some results of the program that were considered questionable.[12] In testimony before the United States Senate Judiciary Committee, former Senator Robert F. Kennedy reported that, in 1963, 615 addicts entered the civil commitment program in Manhattan and by October, 1964, the program had lost contact with approximately seventy-five per cent of them.[13] Despite these statistics and other aspects of the program that came under fire, the Project provided the basis for the latest efforts in New York to successfully attack the overall problem of drug addiction.

NARCOTIC ADDICTION CONTROL COMMISSION. The State's Mental Hygiene Law was amended by 1966 legislation which established a comprehensive program for the treatment, rehabilitation and after-care of drug addicts.[14] The program, administered by the Narcotic Addiction Control Commission has the authority to: establish withdrawal units, screening and diagnostic centers, half-way houses, and day-care centers; contract with other agencies for the provision of various elements of the program; transfer addicts between private and public facilities; certify private treatment facilities; and formulate comprehensive phases of prevention, public education, and research.

The basic program under the auspicies of the Commission has three primary objectives: (1) to provide care for people who are suffering from drug addiction; (2) to provide opportunities for such persons to move in the direction of cure; and (3) to control those who are sent to the Commission for care, interrupt their addiction, and hopefully prevent their re-addiction so as to prevent their return to criminal acts to support it.

Commitment to the Commission's program may be voluntary or involuntary. An addict or any persons responsible for the addict may apply for a court order certifying the individual for inpatient and after-care treatment not to exceed three years. Every person who is arrested for a felony, misdemeanor, or the offense of prostitution and who states, indicates, or shows symptoms of drug addiction is required to be medically examined. If the court finds the person to be an addict and he is convicted of a misdemeanor, he is sentenced to the state program for three years; if he is convicted of a felony the court may commit him to a state prison or may sentence him to the narcotic program for an indeterminate term not to exceed five years.

The treatment and rehabilitation program is designed to vary among the facilities established throughout the state. Individualized treatment is emphasized and includes combinations of group therapy, individual counseling, educational development, pre-vocational training, basic skill building and a gradual phasing back to community living. After-care is commensurate with the program offered in the institutional setting.[15]

The program has received its share of criticisms and comments, since its conception. In 1969, the New York Times conducted a five-month study of the Commission's operations and such terms as "shockingly irrelevant' and "candy-coated penitentiary" were applied to its philosophy and treatment methods.[16] As recently as May 5, 1970, Governor Rockefeller of New York said in regard to the Commission's efforts, "We thought we could set up the structure to do this job," (rehabilitate addicts) "but we have just got to say it's bigger than all of us and that only a total war of the community is going to be able to cope with this."[17]

A new chairman has been appointed to the Commission in the person of Mr. Milton Luger, effective April, 1970. Mr Luger is "determined to eliminate what he calls the Commission's 'credibility gap,' to improve both staff competence and moral, and to create clinically acceptable standards of record keeping. . ."[18]

PASSAGE OF GOVERNOR ROCKEFELLER'S ANTI-NARCOTIC LEGISLATIVE PROGRAM. In May, 1970, Governor Rockefeller signed legislation embodying a broad anti-narcotics program. Elements of the legislation include: $65 million for state aid to local government agencies for operating drug abuse treatment programs; authorization for local governmental agencies to provide such services directly or by contract with qualified voluntary agencies; authorization for the Health and Mental Hygiene Facilities Improvement Corporation to construct, acquire or rehabilitate facilities for use by local agencies in the conduct of drug abuse treatment programs; and authorization for the state housing finance agency to issue an additional $200 million in

notes and bonds to finance the construction, acquisition or rehabilitation of such facilities by the governor. Fifteen million dollars has been allocated to provide methadone treatment for heroin addicts. In addition, the divisionof youth is authorized to establish and operate residential youth development programs to which any youthful addict or drug abuser under the age of eleven may be admitted.[19]

CALIFORNIA. In California, the Director of Corrections in the Human Relations Agency administers a wide range of programs aimed at providing narcotic treatment.

The Narcotic Treatment Control Project was initiated in October, 1959, for the treatment and control of felon parolees with a history of opiate use. The approach was similar to the New York State Parole Project that had begun in 1956. Parolees who relapsed to drug use were sent to special treatment units in San Quentin and the California Institute for Men for periods of up to ninety days. Of 423 experimental parolees released from felon correctional instutions, fifty-two per cent were neither detected using narcotics nor convicted of any crime within six months after their date of parole.[20]

THE NALLINE PILOT PROJECT. California has developed a pilot-system, administered by physicians, aimed at detecting the relapse of drug users to narcotics. The system consists of: (1) Nalline, a synthetic opiate anti-narcotic; (2) urinalysis; and (3) skin-check for needle marks. In the use of Nalline, small amounts of the drug are subcutaneously injected and a significant reaction is noted, primarily in the diameter of the pupil. The technique has been used since 1956 and has been attributed to the reduced re-addiction and crime rate of addicts in certain instances and locales in the state.

Between 1955 and 1959 the predominately addict crimes of robbery, burglary and prostitution were slashed by fifty per cent, and these statistics have been applied to the success of the use of the technique and the concentrated effort to control the addict population.[21] Alameda, San Francisco, and Los Angeles counties and the state parole system use the Nalline technique. The programs in each instance vary but all offer in addition to the Nalline test, specialized caseloads and special probation programs for addicts.

Despite the apparent success of the Nalline appraoch to the detection and control of opiate use, some questions regarding its application have been raised. The use of the test will only detect the use of "narcotics" in the medical sense; that is, heroin -- not methamphetamine or marijuana. The user is not completely free of narcotic effects and a fraction of the subjects experience a heroin-like effect. If the limitations

of the test and the change in the pattern of drug use are not recognized, the test may be applied to users to drugs other than heroin. In at least one county marijuana users may be paroled to the Nalline program; legal within the definitions established by the special legislation afforded the Nalline test. An evaluation of the Nalline programs and the imposition of some slight restrictions appear justified at this time.[22]

CIVIL ADDICT PROGRAM. In 1961, California established the Civil Addict Program that provides compulsory in-patient and after-care treatment and control for opiate users. Addicts are civilly committed by the Superior Court. The proceedings under which the addict may be committed may be initiated in three ways: (1) the addict, a relative, or some other responsible person may approach the county district attorney, who may then petition the court for consideration of the addict's commitment. No criminal charge is involved. Where necessary, provisions are available to detain the alleged addict for medical examination;[23] (2) if any person is convicted of any crime in a municipal or justice court and is believed by the judge to be an addict, the proceedings shall be adjourned or the judge may suspend the imposition of sentence;[24] and (3) any person convicted of a felony (with certain exceptions) may, if the judge believes he is an addict, be referred to another Superior Court to determine the issue of his addiction after he is convicted and the original criminal proceedings are suspended.[25]

All commitments are for the same technical and legal reason -- addiction or "imminent danger" of addiction, regardless of the basis for referral. The criminal matter, if any, becomes irrelevant, as the matter remains in suspended status with the court. Whether the addict is committed voluntarily or not he is bound for a definite period of treatment. The law provides a maximum of a two and one-half year commitment for volunteers and a seven year commitment for others.[26] This term is to include both in-patient and after-care. On an original commitment there is a requirement for a minimum of six-months' in-patient treatment, however, for a returnee there is no limit on length of stay for treatment.

In-patient care consists of intensive group interaction in community living groups, small group work, academic and vocational instruction, recreation, work theraphy, physical fitness, and religious programs.[27] The in-patient phase of the treatment process may be terminated after the minimum time has elapsed and when the professional staff of the institution feels that the person has made sufficient progress to leave. This suggestion is referred for certification to the Narcotic Addict Evaluation Authority which acts in cases of release, return, and discharge.

Upon transfer from the in-patient treatment center to the statewide out-patient program, the individual is supervised by a specially trained field agent who works only with releases from one of the centers. The program offers close supervision, anti-narcotic testing, group therapy, job placement service and halfway houses. Abstaintion from the use of narcotics for three consecutive years may permit the releasee to be discharged from his commitment and the criminal charges against him, if any, may be dismissed by the judge.

Specific provisions of the program, compulsory in-patient treatment, close and continuing supervision in the community, and anti-narcotic testing are a means of forcing the former addict to continue treatment and the results of these efforts have been fruitful. Of the men and women released to after-care treatment, thirty-seven per cent have remained drug-free in the community for one year; approximately twenty per cent have been drug-free and crime free for two years; and approximately fifteen per cent have achieved three years of being drug-free and have been discharged from the program.[28]

NEW JERSEY.

NARCOTIC DRUG STUDY COMMISSION. In 1963, the New Jersey Legislature established the Narcotic Drug Study Commission whose recommendations were passed into law in 1964.[29] Jurisdiction was given to the Commissioner of the Department of Institutions and Agencies and was administratively placed in the Division of Mental Health and Hospitals.

A Bureau of Narcotic Addiction and Drug Abuse was established within the Division of Mental Health and Hospitals in 1967, to carry out the Department's specific responsibilities under the law of 1964. These responsibilities included the establishment of a program of multi-disciplinary effort of prevention, education, psychiatric medical diagnosis, medically oriented after-care community referral, vocational and social rehabilitation, and quasi-legal and legal control in the field of drug addiction. The legislation reflects the view that the drug addiction treatment program is primarily a social-medical approach rather than the prevelant punitive-penal procedure and attitude.[30] In addition, the Act called for the establishment of one or more in-patient residential treatment centers in existing state or county municipal institutions or as new separate facilities. In 1968, the Bureau of Narcotic Addiction and Drug Abuse was transferred from the Division of Mental Health and Hospitals into the office of the Commissioner of Institutions and Agencies to strengthen the efforts of the Bureau and to further improve its working relationship within the Department.

NEW JERSEY NEURO-PSYCHIATRIC INSTITUTE. The first treatment center was established at the New Jersey Neuro-Psychiatric Institute at Princeton in 1965, with bed-space for less than one hundred persons. Most of the persons committed for treatment have been sentenced under the Dangerous Drug Act, which defines persons using drugs as being disorderly. The judge, when giving sentence, is required to give the person the option of serving his sentence or volunteering for treatment.[31] If the individual chooses treatment, his sentence is suspended and he is placed on probation for up to three years; if he chooses to serve his time, the length of sentence is one year.

Voluntary admissions are permitted for persons who are not under legal restraint if the person is twenty-one years old or more, or a married person under the age of twenty. Persons under the age of twenty-one who are not married may be admitted by a parent or legal guardian. In each instance, persons are admitted for treatment only if they agree to remain at least forty-five days.

Those convicted of actual use of narcotics and dangerous drugs and are serving sentences may request re-sentencing and may also apply for admission to in-patient treatment for their drug addiction. Persons awaiting trial may seek treatment if they are found to be acceptable candidates for the receiving facility. Civil commitment has been considered; however, the consensus has been to wait further evaluation of the New York and California experience with this approach and the provisions of the federal Narcotic Addict Rehabilitation Act of 1966.

Treatment in the in-patient phase of the program conducted at the hospital begins with a complete and thorough evaluation of each patients condition and needs. A psychiatric diagnosis is made on each admission as well as the diagnosis of drug addiction. Treatment is directed to overcome the effects of addiction and to relieve the underlying psychiatric problems. Provisions of the 1964 state legislation also called for the establishment of regional after-care centers. All persons with suspended sentences were required to attend the after-care clinic and voluntary patients are encouraged to do so. Two years after the enactment of the legislation establishing the drug program, the New Jersey Drug Study Commission reported to the Legislature:

> The New Jersey experience suggests that a concentrated medical effort alone is inadequate, and for the purposes of rehabilitation of addicts who are returned to their respective communities, a comprehensive program involving cooperating community agencies must emerge.[32]

From these recommendations came important changes in New Jersey's drug addiction program. The medically-oriented approach to treatment has been re-examined and techniques have been developed to motivate and re-motivate addicts toward rehabilitation and judiciously use authority to keep persons enrolled and participating in the program until properly discharged. Pre-admission screening for motivation, explanation of legal requirements and a stipulation making persons ineligible for readmission upon being discharged against medical advice or absent without permission have been instituted.

Another administrative change that came about after the report of the Narcotic Drug Study Commission is that counties are now urged to establish after-care clinics to assist in the treatment and rehabilitation process when the patient is returned to the community. The State does not establish such clinics but does allow for subsidizing county efforts in these areas. Of the twenty-one counties in New Jersey, to date only six have established after-care clinics.[33]

For the last two years, the New Jersey Neuro-Psychiatric Institute has had a methadone treatment program. Before June, 1970 approximately fifty persons were being treated by the use of methadone, however, recent appropriations by the state legislature coupled with an increase in federal funds will allow for the expansion of the program to accomodate an additional 250 persons.[34]

GOVERNOR CAHILL'S LEGISLATIVE PROGRAM FOR DRUG ABUSE. Governor Cahill has called for an increased attack on the problems of drug use in the state and has made the issue one of high priority. One aspect of the Governor's overall program for drug abuse control deals specifically with treatment centers. On June 3, 1970, the Governor signed a $500,000 appropriations bill for continuing and expanding after-care centers in three New Jersey counties.[35] In addition, the governor's program calls for a network of clinics in northern, central and southern New Jersey to be established along with the state takeover of present state funded county clinics.

Proposed by the governor is the establishment of a system of private residential schools for the treatment of juvenile drug users and addicts in New Jersey. Such schools exist in surrounding states but New Jersey has no state-controlled facilities for addicts under the age of eighteen. These schools would be administered by educators and psychologists. There would be staff psychiatrists, physicians and social workers avilable for treatment.[36]

Dr. Lloyd W. McCorkle, state Commissioner of Institutions and Agencies, is conducting a survey to locate 200 beds for juveniles. Revision of priorities of facilities in state hospitals, including beds for juveniles and an expansion in the number of beds presently available at the New Jersey Neuro-Psychiatric Institute is also being considered.

ILLINOIS. Illinois, which had a most serious addiction problem until 1968, had little to offer its drug addicts in the way of rehabilitation and treatment. Until 1968, the primary addiction facility in the state was in the House of Correction in Chicago, a twelve-bed, short-term detoxification unit in the Andrew Cermak Hospital. Approximately 650 addicts are treated annually.[37]

Legislation calling for the civil commitment of addicts has existed in Illinois since 1959. Through the cooperative efforts of the Division of Narcotic Control and the Department of Mental Health, addicts have been committed for treatment to some of the state hospitals. The lack of adequate facilities, trained personnel and structure aftercare, have, for the most part, caused the program in these hospitals to be less than successful.

CREATION OF NARCOTIC ADVISORY COUNCIL. The Narcotic Advisory Council was created by the State General Assembly in 1965. The purpose of the Council was to recommend programs for the prevention of addiction and the treatment and rehabilitation of addicts. With the passage in 1967 of the Drug Addiction Act, the Council began directing the Drug Abuse Program.

The Council recommended that within the program a pilot effort be initiated that would focus on a limited area of Chicago with a relatively high rate of narcotic use. The pilot was to be highly flexible so as to accommodate any changes that may have been necessitated once the population to be served was better defined and understood. In short, various modalities were to be developed. The first program modality included short periods of hospitalization for withdrawal or detoxification purposes, followed by group therapy in the community, the use of oral methadone in the context of a rehabilitative program, the use of narcotic antagonists such as cyclazocine, and residence in therapeutic communities such as Synanon and Daytop Village.[38]

The following program elements were operational by February 1, 1969: an intake process, a pre-treatment phase, in-patient treatment, and assignment to after-care clinics. An intake process is the first phase of the program where applicants are interviewed to determine their acceptability and willingness to be enrolled in the program. In the pre-treatment phase, a person can be carried up to a period of ninety days. During this time, the person's addiction is treated by the use of medication.

In-patient treatment follows pre-treatment and is available in a twelve-bed unit in Billings Hospital. Patients undergo a withdrawal or detoxification process during in-patient treatment. At the conclusion of the abstinence period, they are assigned to after-care clinics in the community. Two such units for after-care exist; each capable of accommodating 100 patients. During this phase, patients are maintained by doses of methadone and participate in group therapy sessions. They also submit urine specimens each time they come in for medication. Two residential therapeutic communities have been established since 1968. The basic emphasis of the program has focused on the creation of these facilities and they have been supported by a grant from the Drug Abuse Program.

To date, the main efforts in the treatment and rehabilitation of those addicted to drug use in Illinois have centered in the immediate area of Chicago. If the rehabilitation budget is enlarged, other such efforts will be expanded to other portions of the state as new programs are developed. The basic overall plan is similar to that of New York State. At this juncture, experience is limited and careful evaluation as to the effectiveness of the efforts to date will be made before any substantial increase in the scope of the program is initiated.

LOCAL TREATMENT FACILITIES AND PROGRAMS.

The attack on the abusive use of drugs and the development of facilities and programs that will make inroads in the successful treatment and rehabilitation of drug users has not been limited to just efforts on the part of federal and state programs. Specific municipalities have also initiated public means of support for programs. Some of these efforts will be discussed in this section dealing with public (federal, state and local) programs aimed at providing treatment and rehabilitative services for the drug addict.

NEW YORK CITY. In the spring of 1967, New York City initiated a program of drug abuse treatment and rehabilitation financed through the cooperative resources of federal, state, and city governments. Staffed by former addicts and mental patients, the program is housed at the Rikers Island Correctional Institution for Men. Less than one year after its beginning, the program was servicing 600 individuals.

The basic tenets of the program conducted at Rikers Island consists of endless confrontation between groups of addicts who brutally assess each other's self deceptions; a series of "games" intended to instill self-honesty, responsibility, and concern for others, and slogans.[39] This program emphasis has evolved from the description of the addicts by the director of the program, Dr. Efren E. Ramirez, who sees addicts as suffering from a "character disorder" manifested by self deception and "copping out," and by a "lack of will power, motivation,

and the ability to plan ahead."[40] During the three year treatment process patients are engaged in vocational and specific group activities designed to overcome their weaknesses as described by Ramirez. Persons are given menial jobs to perform when they first come to the facility and are encouraged to use their spare time working in an area of potential vocation. Ultimate work assignment, and one which carries a high degree of status, is in the storefront centers located in high addiction areas. Group activities center around a series of group therapy sessions designed to teach addicts to delay their outbursts of aggravation until an appropriate time when they may confront the source directly instead of seeking to escape from the problem. Some sort of solution to the aggravating situation must be presented so that appropriate action will come about.

Some critics of the program have felt that it is not really "reality-oriented" and addicts will not be able to deal with the world in general in the same manner as they are being trained to do within the program. The use of former addicts in the program has also raised questions because of their lack of formal training and the general feeling that it is unprofessional to use them in this capacity. In addition, there is the feeling by some, that patients who enter the program must be motivated to seek help before entering the program, otherwise, their stay in it will not be successful.

Despite these criticisms, Dr. Ramirez feels that "every addict is curable until proved otherwise. We teach people to be proud of their manhood, instead of being a proud man. The code of the street isn't the important thing. Pride in your work, doing a good job, being responsible, that's what it means to be a man."[41]

SAN FRANCISCO. Emergency clinics staffed by a nurse, a psychiatric technician and student aides have been established in four San Francisco high schools. Called "crash pads," the clinics have been set up for students who have been overcome by narcotics. Officially, the clinics have been established as part of an experimental project that has three goals: (1) to save the lives of students overcome by drugs; (2) to preserve and promote the health of students misusing or about to misuse drugs; and (3) to redirect students to seek alternatives to drug use.[42] Specifically, the clinics have been looked upon as filling the need for ". . .a rap center, where kids can get accurate drug information with no moralizing and relatively little judging; where they can talk about personal problems with other students, social workers or teachers -- and feel safe doing it."[43]

Initial curiousity was high among students and many used the facility as an escape mechanism from non-motivative classroom instruction. The overall worthfulness of the facility is also being demonstrated as exemplified by the following remarks by a teacher:

> I asked a girl why she takes dope. She told me she's buying time until she's eighteen and can get away from her mother. You don't solve problems like that with a lecture on the evils of pot.[44]

FORT BRAGG, CALIFORNIA. Fort Bragg, California is a small coastal town some 200 miles from San Francisco. The high school in Fort Bragg has a student population of 550 who responded to a survey in the spring of 1968 that revealed that fifty per cent of the seniors had experimented with drugs.[45] Shocked by the realization that such a large segment of the student population was involved with drugs, the schools and the community recognized the situation as a problem and set out to do something about it. According to Mr. Bruce Brooks, a school counselor:

> We looked around for someone or some program to help. We found no one could. There were some drug problems in other schools, but they were based on trying to scare the students. The kids are too smart to believe a completely negative approach. That doesn't work. Then we heard about the "family" program at Mendocino State Hospital."[46]

The Mendocino "family" program centers around self-help with addicts helping other addicts. The program was extended into the high school using two ex-addicts from Mendocino as counselors.

Funds were collected to keep the program going during the summer months and during the 1968-69 school year, a full-scale program was launched in the high school. Both users and non-users of drugs were encouraged to attend group sessions at the school and at an Awareness House that had been established. The basic idea of these sessions was to get the youngsters involved in life through the use of people instead of through the use of drugs. The group therapy centers utilize a simulation-gaming structure wherein students confront each other to tell the truth about the various problems that have led them or are leading them to the use of drugs. This search for truth helps students to knock down any walls of rationalization that may have been created and helps them to communicate with each other and with adults about the things that bother them.

The use of ex-addicts in the program had given some parents misgivings about their youngsters being involved. This initial apprehension has been dissolved and the towns' school district has been the recipient of a training grant from the Education Professions Development Act (EPDA) to train and involve an additional twelve ex-addicts. These individuals would be used to expand the program by working with some 20,000 high school students who reside in Mendocino County and three other counties. The expansion process has been successful and plans

are now being developed to establish "family" programs in hospitals so that the community program will become an extension of the hospital program.

CHESTER, PENNSYLVANIA.[47] In January, 1969, a community facility aimed at providing a treatment center for teen-age drug addicts was opened in Chester, Pennsylvania -- a small community not far from Philadelphia. The center was initiated by a Chester physician who through his private practice and experiences with children of friends became aware of the need for such a facility. Called SODAT (Service to Overcome Drug Abuse Among Teen-agers) House, admission to the center and its program of treatment can be both voluntary or by referral. In either case the patient, or prospective patient, must show a high degree of motivation for treatment prior to admission. Upon acceptance, if the patient is addicted to one of the opiates, he is admitted to the Crozer-Chester Medical Center where the methadone treatment is utilized to carry the patient over the withdrawal or detoxification phase. After successfully completing withdrawal, the person is turned over to a clinical psychologist who uses a group therapy technique. The third element of the treatment process involves the support of local industry who will hire former addicts so that they can become useful citizens of society once again. Support for the program has been growing over the months since SODAT House was first opened -- community acceptance, police cooperation and local college support in the form of utilizing senior psychology students as counseling aides.

A few critics of the program and its methods have voiced their objections and protest the information disseminated by SODAT House. It is felt that this information tends to arouse curiousity about drugs rather than dispel it. The center's founder, Dr. Leonard Rosen, is not dismayed by these protests, however, and points to the fact that the center has thus far treated many youngsters as young as ten years old and the evidence in the junior and senior high schools indicates that a problem exists and constructive efforts to remediate the situation like SODAT House should be encouraged to continue and expand.

PRIVATE TREATMENT AND REHABILITATION EFFORTS. Up to this point, the discussion of treatment facilities and programs has centered on the provisions made by public -- federal, state, and local -- governments in dealing with the problems of drug addicts. In addition to these facilities and programs, many private agencies have initiated residential care and treatment houses for the addict and have designed new programs or rehabilitation, or adapted specific programs to meet particular situations and needs.

ADDICTS REHABILITATION CENTER. The Addicts Rehabilitation Center, located in the Harlem section of New York City, is a private non-profit agency supported in large part by the New York State Narcotics Commission, the Christian Reformed Church and other private groups. Now in its tenth year, the center presently services

approximately 75 narcotics addicts, who are primarily teen-agers between the ages of fourteen and seventeen. Patients who enter the program have either been referred by an agency such as: parole, probation, welfare, hospital and/or rehabilitation; or come in off the street and seek treatment.

The treatment process involves a high concentration of group therapy, vocational and educational counseling, and general preparation for return to the community: "One unique feature of this program is that it is developed not according to scientifically documented procedures but according to the experiences and pressures and problems of the people."[48] Group therapy, as mentioned, plays a large part in the rehabilitation process. Each addict must face the appraisal of other addicts in confrontation sessions designed to help him accept reality as it relates to his own circumstances. An excerpt from such a session exemplifies the type of dialogue that is exchanged between addicts:

> Girl: My problem was that I couldn't speak in the house. Like I used to want to sit down and talk with my parents and tell them my problems, but they used to tell me what was wrong with me, and they never let me speak. Dope? Like all my friends were taking it, and they said it was good and I should try it, so I tried it.
>
> The Reality-Getters: She's lyin. When she first sniffed, she didn't say to herself she was doin' this to get even with her mother. There's more to it.
>
> She wanted to be slick, that's all. Maybe she dug those fast broads ridin' in a Cadillac! What fascinated you with the use of drugs? You feel a sense of Bigger? You know, you was fast, you was hip, you was down with it. Tell me, what fascinated you?
>
> Didn't you see the dope fiends? Their arms were like abcesses; they looked like dogs! Right? You mean to tell us you let some of your friends persuade you![49]

The Center has had its share of successes. Of the 73 graduates from the program in 1968, 56 were gainfully employed, and all but three of the remainder have returned to school.[50]

THE MOUNT CARMEL GUILD NARCOTIC REHABILITATION CLINIC. The Mount Carmel Guild in Newark, New Jersey has provided, since 1961, a drug addiction treatment and rehabilitation program. The program had been established on the premise that addicts can be rehabilitated in their homes, with their own families, and in their own communities on a voluntary basis.[51] During the year 1968, the Guild treated 479 drug abusers through the means of individual and group therapy.[52] At the outset, each patient is evaluated psychologically to determine

the degree of motivation that brings him to the program. It has been the experiences of those working in the program that unless an individual is highly motivated to succeed in the treatment and rehabilitation process, the program does him little good.

Individual and group therapy for the addicts immediate family and relatives is also an intrinsic means of treatment. This therapy is provided with the realization that part of the addicts problem lies in his familial adjustment; therefore, to treat the addict in a realistic way, the family must also be part of the process. Other aspects of the program include: introduction to job opportunities and placement, assistance in acquiring high school equivalency, recreation, and a referral service to other community resources as required by the patients special needs.

DRUG ADDICTION REHABILITATION ENTERPRISES (DARE). Drug Addiction Rehabilitation Enterprises (DARE) is a three year-old rehabilitation program supported primarily through private funds. It maintains outpatient drug treatment services in Newark and Summit, New Jersey, and another in-patient center in Island Heights, a shore resort in New Jersey. With the recent purchase of another house next to its Newark facility, the organization is now able to accept youngsters as young as fifteen years of age. The finalization of a high school equivalancy program through the cooperation of the Newark Board of Education has enabled the offering of services to youngsters of school age. Receipt of a federal grant to aid in the staffing of the centers will bolster the current staff of nine that includes a physician, psychologist, and five ex-addicts who work with those seeking treatment.

The DARE rehabilitation program is based on group discussion, work, and a strong desire on the part of the addicts to be helped. Richard Roselli, founder and director of DARE has stated:

> We believe young people in particular have a strong desire to be cured. When a youngster believes he has had it with drugs, there is no reason why he can't be rehabilitated back to a normal life.[53]

DAYTOP VILLAGE. The provision of a residential or community setting in which the addict can live to overcome his need for drugs and be rehabilitated is the premise on which Daytop Village functions. Originated in New York City where three facilities are now able to help some 450 persons at one time; Trenton, the state capital of New Jersey, has become the site of the first such "village" outside of New York City.

Anyone who shows a sincere desire to be helped is accepted. The only demands made are: no chemicals, drugs or alcohol may be used; no violence or even threat of violence is allowed. An individual's degree of sincerity is measured by the staff, all ex-addicts, who feel

they can tell one someone is insincere about wanting to be helped because they have been in that position themselves.

The process of treatment includes: withdrawal, work, and therapy. Before an addict is accepted he must agree to free himself of drugs. When asked about the withdrawal process, Jim Halloram, the director of the program, has commented: "Withdrawal is not that bad. It's no worse than a case of the flu, and they go through it right here with everyone around them."[54] Withdrawal is followed by a short period in which the prospective resident assists maintaining the facility in which the center is located and is accompanied by his participation in discussions. Once eligible for residency, the patient is accepted into one of the residential facilities.

During his tenure as a resident, which usually lasts about twenty months, the individual is assigned menial jobs initially, followed by responsible assignments as his degree of responsibility increases. During this time therapy is provided by all enrolled in the program and by the staff through the means of periodic group sessions. Peer group acceptance is emphasized at Daytop and with it the hope that each ex-addict will gain a sense of responsibility, not only to themselves but to others as well.

The previous section dealt primarily with the various types of treatment and rehabilitation facilities and programs for drug addiction that exist as the result of public and private financial support. In some instances a description of the program could not be presented without some incidental mention regarding the nature of the method of treatment offered. A more comprehensive account of methods of treatment for drug addiction is warrented; however, in view of the fact that particular approaches have received a considerable share of publicity in both the professional and non-professional literature, questions may exist in the mind of the reader regarding them.

TREATMENT: METHODS.

TREATMENT THROUGH THE USE OF SYNTHETIC DRUGS.

Within recent years experimentation in the use of synthetic drugs as a means of treating persons addicted to narcotics has been conducted in various institutions. The results of this experimentation have provided two techniques in particular that have received the greatest amount of attention, both in the literature and in their actual use.

CYCLAZOCINE.

It has been proposed that the regular administration of cyclazocine, a long-acting narcotics antagonist, might be useful in the treatment of highly motivated, ambulatory patients to avoid relapse to the compulsive use of narcotics.[55] When cyclazocine is given in appropriate doses, it reduces the subjective and physiological effects of any morphine-like drug.[56] The regular use of cyclazocine reduces or prevents the development of physical dependency on morphine-like drugs. Patients pre-treated with cyclazocine in appropriate doses will not feel the effects of ordinary doses of morphine-like drugs and will not become physically dependent even with regular use of such drugs.[57]

In a study conducted at the Albert Einstein College of Medicine, it was hypothesized that in addition to any character disorders that may have led to narcotics use, the narcotics dependent individual has acquired a complex set of classically and instrumentally conditioned responses.[58] This conditioning has a tendency to relapse to narcotics use when the individual returns to the environment in which drugs were used. The administration of cyclazocine in daily doses controls the use of morphine-like drugs on the part of the patient once he has returned to his environment and becomes an effective means of treating his drug dependency problem.

In current studies conducted at hospital facilities in New York City, the use of cyclazocine was in itself found to be ineffective in the rehabilitative process and that individual and group helping services needed to be built in as well.[59]

The drug served as a lever in therapy by stabilizing patients and by blocking the effects of their drug use. Used in this way, the drug allowed the process of rehabilitation to be more rapid and efficient.

Treatment through the use of cyclazocine does not appear to provide the patient with the opportunity to be completely abstinent from the use of other drugs. Patients may reduce their use from full addiction to occasional use and may resort to irregular shots of narcotics because they no longer fear the danger of addiction.

Research for an additional drug that will have the same effects as cyclazocine but with longer lasting application is now being conducted. This new synthetic would last for seven to ten days and would alleviate the necessity for daily maintenance. In addition, longer maintenance would remove the temptation on the part of the individual to use other drugs.

METHADONE. The one synthetic drug used for therapuetic purposes that has received the greatest amount of attention and generated the most controversy has been a synthetic addicting opiate called methadone. Research begun in 1964 by Dr. Vincent Dole and Dr. Marie Nyswander at Rockefeller University in New York indicates that methadone, when administered appropriately, blocks the action of heroin; eliminates the drug craving, which drives many detoxified addicts to resume heroin addiction; and produces neither euphoria or other distortions of behavior.[60]

Methadone was brought to the United States from Germany after World War II. It was administered as a synthetic pain killer during the War when the Germans were in short supply of opiate derivatives. Since the War, it has been used in Europe as an analgesic.[61] The experimentation of Drs. Dole and Nyswander was among the first directed at employment of the drug in the treatment of heroin addiction.

DOLE AND NYSWANDER PROGRAM. Dole and Nyswander attribute drug addiction to a metabolic deficiency and tend to question psychological factors.[62] They have designed their experimental program into two phases: During phase one the patient undergoes an initial six-week in-patient period where oral doses of methadone dissolved in orange juice are administered. The doses are increased until a stabilizing dosage is reached. If the medication is given in proper doses euphoria or undiserable side effects during the stabilization period should be non-existent. In phase two of the program the patient is allowed to return to his community setting but is required to return to the clinic each day to take his supervised oral dose of methadone. Patients give

daily urine samples to be analyzed for traces of illicit drugs. Eventually, if warrented by good conduct, patients are provided with several days' dosage at a time, and return once or twice a week for urine analysis and other tests.[63]

Withdrawal from methadone is not, as of now, a part of the treatment process. Indications are that once withdrawn from methadone, patients experience a return of the narcotic hunger and revert to the use of heroin.[64]

During each phase of the program patients are provided with supportive services to aid in their rehabilitation. These supportive services are in the form of psychological, social and vocational support. A wide array of therapists in each of these disciplines is utilized to assist the patient.

As of May, 1969, the program had admitted 1300 patients selected according to the following criteria: at least four years of mainline heroin use; failure at previous attempts at withdrawal treatment; age 20-50; no legal compulsion to treatment; and no major medical complications such as severe alcoholism, epilepsy, or schizophrenia.[65]

An independent evaluating committee has concluded that methadone maintenance is an effective form of treatment for a substantial number of selective heroin addicts. None of the 82 per cent of the patients remaining in the program became readdicted to heroin, and the majority became rehabilitated as determined by school and employment records and the decrease in anti-social behavior, including number of arrests. Following thirty-six months of treatment, 92 per cent were employed in school or were homemakers; 8 per cent were receiving welfare; and 2 per cent had been arrested.[66] Problems have been encountered with continued drug abuse. The committee recommended that methadone maintenance programs should either screen out those patients with mixed addiction or be prepared to cope with the problem.[67]

The evaluation committee also recommended that there be continued support for the treatment method program and that there be continued in-take of new patients with evaluation of the long-term effectiveness of the program. It pointed out that new treatment programs should include specific elements of the Dole-Nyswander program. The committee saw methadone maintenance as a method of treatment but not suitable for use by the private practioner in his office because of the necessity for specially trained staff and because answers are needed regarding the proportion of the "addict population" that can be successfully treated.[68]

OPPOSITION TO METHADONE. Despite the positive reaction of the evaluation committee regarding the efforts to use methadone maintenance as a means of opiate drug addiction, there exists much opposition to its use on social, medical, and legal grounds.

SOCIAL OPPOSITION. Addicts who have chosen to become totally abstinant from the use of drugs via the "cold turkey" approach have voiced strong opposition to any treatment method that uses synthetic drugs to maintain an addict. These opponents see more worth in reliance upon half-way houses as Phoenix House, Synanon and Daytop Lodge to keep them drug free by living with other former addicts in a structured setting. They reason that addicts maintained on methadone will be deprived of an opportunity to ever be drug free.[69] Cazalas and Bucaro[70] contend that this is not a valid argument since a maximum of only 10 per cent of the addicts seeking total abstinence remain drug free one year after discharged from programs conducted at Lexington, Kentucky and Fort Worth, Texas.[71] It is also believed that the same modality of treatment is not desirable for all addicts, and those who are addicted to the drug habit without the use of methadone but are rehabilitated with it should not be denied the right to choose the method of treatment best suited for them.[72]

MEDICAL OPPOSITION. Another source of opposition has come from medical societies. The American Medical Association is still being quoted by the Bureau of Narcotics and Dangerous Drugs in its regulations to physicians as being of the opinion that maintenance of an addict is inadequate, medically unsound and unethical.[73] A doctor who conceives of treatment only in terms of abstinence would agree with this point of view and subscribe to the idea that the methadone maintenance process merely substitutes one addiction for another and is not treatment at all.[74]

The Bureau of Narcotics and Dangerous Drugs has had a philosophy that all addicts are amoral animals and depraved criminals, seeking to satiate their illegal craving for drugs. The Bureau is a proponent of treatment by incarceration; it considers clinics maintaining addicts with methadone to be filling stations whereby the animalistic craving is satisfied.[75]

Another objection by the Bureau to the maintenance program is that the use of methadone is still in the research stage and may not yet be considered established treatment. It is concluded that methadone maintenance is acceptable only if programs are kept small and are structured to answer specific questions, rather than to provide therapy.[76]

In March, 1969, Donald Miller, Chief Counsel of the Bureau of Narcotics and Dangerous Drugs, wrote:

> Some persons claim that adequate 'research' has been done, and that a positive 'treatment' program may be established. Again, the Bureau has looked to the views of the representative medical bodies, which have concluded that methadone addiction maintenance remains a research undertaking, and that it cannot be considered as established treatment. In order to be considered as 'treatment' it must be more than promising -- it must be proved . . . The Bureau does have a vital role, even if it is only to act as a catalyst against mass acceptance of a theory which could adversely affect our society. . .[77]

Dole contends that the basic maintenance program has been proven medically acceptable for at least that addict population described by his own selection criteria.[78] The risks of treatment are believed to be negligible, the benefits to the patient and to society are substantial, and likely proportion of failures is predictable and communicable to the patient; therefore, it has been suggested that Dole's program be considered a valid form of treatment.[79]

LEGAL OPPOSITION. Legal opposition to, or problems encountered by, the use of methadone as a means of treatment stem from provisions of the Federal Food, Drug, and Cosmetics Act and the Harrison Act. The Federal Food, Drug, and Cosmetics Act provides procedures to assure that "new drugs" will not be introduced into interstate commerce until their safety and effectiveness have been proven.[80] Before a "new drug" can be marketed on an interstate basis the Food and Drug Administration must approve a new drug application; where sufficient proof is lacking that a new drug is safe and effective, an alternative procedure permits the manufacturer of the drug to send it into interstate commerce for testing only.[81]

Despite the fact that methadone is not a "new drug" in the usual sense, in that it has been used as a pain killer for many years and has gained wide acceptance as a means of treating heroin addiction, the drug would require new drug approval if it were marketed in interstate commerce for a new use "not generally recognized as safe and effective."[82]

> The standards for new drug approval incorporated in the 1962 amendments to the Food, Drug, and Cosmetics Act suggest that approval for methadone in a main-

> tenance use should be granted. Since the criteria permit and even direct approval where medical opinion is split, FDA approval of methadone in its new use would be justified. If, however, the FDA should be unwilling to classify the use of methadone for maintenance purposes as safe and effective, maintenance programs could still continue under the investigational new drug exemption.[83]

In 1914, a federal regulatory measure required the registration of narcotics dispensers, imposed an excise tax on narcotic drugs, and limited the sale and distribution of narcotics to recipients who used a written order form, was enacted and is presently referred to as the Harrison Act.[84] Administration of the Act is placed with the Bureau of Narcotics and Dangerous Drugs which issues regulations for the administration of narcotics but expresses no intention to interfere with their "good faith" use by physicians engaged in the "legitmate practice of medicine."[85] However, "physicians have hesitated to treat addicts because only after a court trial can their "good faith" in the course of "legitimate practice of medicine" be determined -- a procedure which may result in the loss of their right to practice medicine."[86] The Bureau has issued a regulation in regard to this question which states:

> A prescription, in order to be effective in legalizing the possession of unstamped narcotic drugs and eliminating the necessity for the use of order forms, must be issued for legitimate medical purposes. . .An order purporting to be a prescription issued to an addict or habitual user of narcotics, not in the course of professional treatment but for the purpose of providing the user with narcotics sufficient to keep him comfortable by maintaining his customary use, is not a prescription within the meaning and intent of the act; and . . .the person issuing it, may be charged with violation of the law.[87]

The Bureau has also leaned upon statements made by the American Medical Association, and the National Research Council for interpretation regarding the use of such drugs as methadone. A joint statement by these two organizations has said that: "continued administration of narcotic drugs solely for the maintenance of dependence is not a bona fide attempt at treatment, nor is it ethical medical practice."[88] The Bureau of Narcotics and Dangerous Drugs in addition to its own policy, has used the statement by the AMA and the NRC to conclude that methadone maintenance treatment programs are illegal. The Bureau has allowed limited methadone programs

to proceed on the basis that they are investigational programs and are provided for under the AMA-NRC statement which does make provisions for research.

Guidelines that dictate to physicians how they may conduct research with methadone maintenance are now being drafted by the Bureau of Narcotics and Dangerous Drugs, however, treatment by this method is expressly prohibited.[89] The guidelines call for the provision of individual and group therapy; psychological testing; proof of employment or school attendance; special caution regarding the handling and preparation of methadone; and a special word to program directors emphasizing that eventual diminuation of methadone dosage levels should be anticipated and that the ultimate goal of the program should be withdrawal of the patient from methadone and less addicting drugs with his return to the drug free state.[90]

TREATMENT THROUGH THE USE OF PSYCHO-SOCIOLOGICAL MEANS. The term "psycho-sociological" is being applied to those treatment methods and their practitioners that do not believe maintenance with synthetic drugs is an effective means of treating drug addiction but advocate instead the use of structured settings, specific therapuetic techniques, and other methods of treatment to affect the rehabilitative process.

There are those who contend that drug addicts suffer from character disorders which causes them to express their conflicts by behavioral manifestations. Individuals of this description present complex and long-standing problems and an extreme degree of social pathology in all their familial and community relationships.[91] In recognition of this, it has been suggested that only limited goals be set in the treatment and rehabilitation of addicts and that primary emphasis be placed upon allowing the addict to develop the means for curbing and limiting his acting out behavior.

"RATIONAL AUTHORITY". Brill[92] cites the development of a method of treatment using "rational authority" as its basis. Through the use of authority as exerted by specific agencies, a structured treatment relationship has been developed to allow the addict to eventually internalize the controls placed upon him. The authority used in the program cited by Brill came from the cooperative efforts of the Washington Heights Rehabilitation Center and the courts of the City of New York. Through the efforts of these two agencies it was hoped that a graduated series of deterrent measures could be developed that would brake the acting-out behavior of patients and help them avoid relapse of drugs. The program is still in its early stages and evaluation is not complete, however, Brill has stated that: "It was. . . the central use of authority that served as the impetus for the better adjustment of patients."[93]

SUB-COMMUNITY SETTINGS. The advent of structured community settings such as Daytop Village and Synanon, as a means for treating and rehabilitating drug addicts, have come about as the result of the conviction that the most effective way to rid an individuals addiction to drugs is through abstinance and supportive therapy. Control of the individuals behavior including his use of drugs is achieved by the fact that he lives within a sub-community created for the exclusive purpose of treating and rehabilitating his addiction to drugs. The use of any drugs, alcohol, or other kinds of stimulants are forbidden while the individual is a member of the sub-community and he may actually be excluded from it if there is use of any of these.

Supportive therapy is another major element in the treatment process and usually takes on the label of "encounter therapy." In "encounter therapy" a specific treatment relationship is used to promote the personal growth of all the individuals involved. A definition of a treatment relationship has been offered by Deitch and Casriel who have stated:

> A treatment relationship is any situation in which two or more persons encounter each other as equal human beings with a sense of challenge, and with responsible concern rather than indulgence.[94]

The need to submit to the comments of others regarding ones own behavior and to also encounter or challenge the behavior of others is a necessary ingredient of any therapuetic relationship if an individual is to grow and understand his own behavior and eventually control it in more socially acceptable ways. Any treatment that evolves from sessions involving one or more persons demands a more human kind of involvement from the therapist and . . ."leads ideally, to a fuller, more mature kind of growth for the individuals concerned."[95]

Any person who accepts the responsibility for the treatment of drug addicts by means of "encounter therapy" must be willing to be open to challenge concerning changes in his own behavior as it relates to his own actions and ideas. He must accept that he will relate to drug addicts in a manner that reflects their dignity as human beings. He must not see their addiction, or general behavior, as a reflection of weakness but must perceive the patient as an individual who is capable of achieving his aspirations and reducing his failures.

The success of these programs and their form of therapy has been questioned. The main consensus is that whatever success these methods may have achieved has been within the sub-community settings in which the patient lives. Reintegration of

the patient into the general community has not been as successful.[96]

CAUSE AS A DETERMINER OF TREATMENT. Another theory regarding treatment has focused on the causes of drug use by an individual and has resulted in the thesis that not one particular means or method of treatment is appropriate. Solomon has suggested that drug dependence may be classified as social, neurotic, or psychotic, depending on the chief underlying cause. Solomon feels differentiating the three types is important, since the proper management of each is distinctly different.[97]

SOCIAL DRUG DEPENDENCE. Social drug dependence is a manifestation of being with the crowd and doing what it dictates is acceptable, and/or the seeking of pleasure in a euphoric state similar to that achieved by the consumption of alcohol. Marijuana and the amphetamines are the drug agents usually used to achieve the states described and appear to be most prevalent among young people who use drugs.

In his description of types of drug dependence and their characteristics, Solomon sees dissatisfaction as the basic symptom subserved by social drug taking; unfulfillment and rejection being the patients fear; identity, status and pleasure as being the goal of those who are socially dependent on drugs; and education as being the chief means of treatment.[98]

The parents of young people who use drugs are, according to Solomon, the agents who can best effect the change in behavior needed to see the youngsters through a time of drug dependence:

> If only they (parents) can continue their moral support and the example of their own presumably staunch lives, then 'this too shall pass,' and the children will come through and survive. 'Hippiness' and the craze for drug taking will run the course of other fads of the past -- the hip flask, Hoola Hoops, swallowing live goldfish. Of course, drugs are far more dangerous, but the same principles of management hold; tolerance, patience, trust and confidence, love and respect, continued gentle pressure in healthy directions, and above all, an unabated sense of humor. . .[99]

NEUROTIC DRUG DEPENDENCE. Neurotic drug dependence is characterized by the drug users basic anxiety about life and his place in it; his fear of suffering; and his attempts to relieve his anxieties and suffering by using drugs. The chief means of treatment is psychological.[100]

Emotions are the basis for a neurosis and taking drugs can seem to serve as a temporary escape for a person whose emotions and tensions appear to be reaching the breaking point. There may be many other motivating factors besides escape that force an individual to take drugs. Some may be completely unaware of these forces but use drugs to release themselves from basic inhibitions. No matter what the causes, conscious or unconscious, drugs serve the user as a means of release.

The means of treatment suggested by Solomon is the treatment offered for a neurotic person. His suggestions come from his work with college-aged drug takers:

> From the start, demonstrate that your chief interest is in the patient himself, not in his parents or their views nor in his drug taking as such.
>
> The relevant elements in the past events usually come out incidentally as you explore the present in depth.
>
> Do not let yourself be trapped into expounding your own views on important subjects like sex, fidelity, honesty, duty, drug taking, or law and order.
>
> Do not argue, even when the patient is saying something you find especially repugnant. Accept his right to say it and continue to listen attentively.
>
> Help the patient to identify his "hang-ups (conflicts or crucial problems). Let him see that in his dilemmas it is he who must make a choice.
>
> Investigate and bring to light smouldering problems.
>
> An investigation in depth of the young person's emotional makeup and problems doesn't have to produce solutions in order to be of significant help.[101]

PSYCHOTIC DRUG DEPENDENCE. Psychotic drug dependence occurs in persons who live in a world of unreality. Their behavior may be bizarre or seemingly quite normal but the basis for their condition tends to alter their feelings and as a result they become controlled by their feelings rather than having control over them. Many persons who suffer from psychosis may be led into delinquency, crime, alcoholism, or drug dependence.

> Though there is much yet to be learned about the causes of the psychosis, experience indicates that an individual case may often be precipitated by a physical or psychological cause . . .The resulting psychosis, though usually

> toxic and acute, may be chronic, sometimes lasting many months or years. Treatment involves the use of (various medicines), electric shock therapy, hospital-milieu care, and psycho-therapy, the last being largely supportive in nature.[102]

As the previous discussion indicates, methods of treating and rehabilitating drug abusers vary in their goals, techniques, and eventual results. Despite the variations offered, there are basic social aspects that should be considered by society, in general, and by individuals who attempt to help the drug abuser in specific, direct ways. A few of these aspects have been offered for consideration by Strack,[103] who recently wrote:

> First, society must accept the existence of, and differentiate between, the spree or occassional drug abuser and the chronic abuser for whom abuse has become a way of life. Second, the chronic abuser is a sick individual, and however society chooses to provide care and custody for him, he should be treated as a sick man. Third, drug abuse is a symptom of some deeper, underlying disorder. It may range on the one hand from adolescent rebellion to deepseated character disorders on the other. In all of these, loneliness and alienation play a large role.

FOOTNOTES

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[25]Ibid., § 3051.

[26]Ibid., § 3201.

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LEGAL ASPECTS OF DRUGS AND DRUG ABUSE

This chapter on legislation presents a discussion of the current federal and state laws regarding the control, prevention, treatment, and education efforts concerning drugs and drug abuse. In addition, a description is provided of a model state legislative program that may be applied as a partial solution to the problem of drug abuse.

In surveying state and federal legislative action, one sees a legislative spectrum running from imposition of the harshest penalties to failure to enact any legislation at all. The present drug legislation is based in part on the long-established philosophy that society should keep individuals from doing harm to themselves, even if they harm no one else directly; and in addition, to reflect society's concern for indirect harm that individuals do to other people.

THE PRESENT LEGISLATIVE STRUCTURE.

The majority of states approach the legislative control of all drugs in a uniform manner that ignores varying physiological and psychological effects on the body. Federal legislaton, based largely on the Uniform Narcotic Act of 1932, distinguishes between "hard" drugs (e.g., morphine, opium, heroin) and the "soft" drugs (e.g., marijuana). Many states subsequently followed this simplistic division of "hard" and "soft" drugs and continued to use the "soft" drug classification when the depressant and stimulant drugs as well as the hallucinogens came into popularity. The effect of this was an incongruous array of statutory provisions in no way relating punishment to the potentiality for physical harm. In addition, this improper classification results in the establishment of penalties which are greatly out of proportion to the crime committed. [1]

One of the most objectionable features of the laws is the fact that a person with a drug problem is discouraged from seeking medical help. Massachusetts law, for example, requires physicians and hospitals treating persons suffering from the chronic use of narcotic drugs to furnish the Department of Public Health a statement giving: name, address, height, weight, date of birth, color of eyes, color of hair, date treated, and the name of the narcotic drug the person used or suffered from. The physician who refuses to comply with this law, which constitutes a mandatory breach of the confidentiality of the physician-patient relationship, may be punished by a fine of $2,000 or two years in jail for the first offense. [2]

IMPACT OF PRESENT LEGISLATION. The question must ultimately be asked as to whether the punitive orientation of the present drug laws is effectively deterring young people from using these drugs. The incidence of drug use as indicated in the spiraling number of arrests and reported in the surveys taken among young people suggest that it is not. [3] Social scientists explain that to deter, punishment must be impartial, immediate, and supported by a wide consensus of informal social beliefs. [4] Despite the nation's massive expenditures in police time and money, smoking of marijuana is now so widespread that there are approximately 25 times as many users as there are places to hold them in all the nation's prisons. When somewhat comparable enforcement of the Volstead Act prevailed during Prohibition (See Chapter I, p.2), the nation's per-capita consumption of liquor actually increased ten per cent. [5]

The apparent double standards for alcohol and marijuana, and the zeal with which drug laws are applied when other social problems go unattended, makes it difficult for young people to believe adults' warnings about other drugs and discourages the young who need medical help and advice from seeking it. Dr. Sidney Cohen, formerly with the National Institute for Mental Health, has stated: "Drug abuse is primarily a medical and social problem made worse by severe laws with harsh mandatory penalties."[6] In addition, Senator Harold Hughes of Iowa and Chairman of the Special Senate Subcommittee on Alcoholism and Narcotics has said: "Why, instead of following sane and progressive recommendations, do we continue with a system that busts up kids' lives and makes treatment of addiction impossible?"[7]

The gangster-style raids, the ineffective prosecution, and the inconsistent results of justice, depending upon the orientation of the police, prosecutor and judge, suggest that change is eminent. It is far more likely that the answer lies in research, in treatment, in education, and more important, in frank discussion of the problem; than in the application of harsh punitive measures which can do little more than give a criminal orientation to a youngster already severely disturbed.[8]

LEGISLATIVE PROGRESS. According to Neil L. Chayet,[9] Connecticut has perhaps the most comprehensive and forward-looking legislation dealing with drug abuse. This omnibus act, which took effect on October 1, 1967, covers both marijuana and LSD, but explicitly separates the two according to their respective effects and provides different and appropriate penalties. Connecticut's new statute parallels the focus of the federal law -- an attempt to destroy illegal traffic at its source, rather than on imposition of stringent penalties on the user. One of the most significant provisions of the law is that is provides for an alternative to a jail sentence -- that is, medical treatment.

In addition, Connecticut legislation provides for both medical and psychiatric treatment to cope with the dependency factor and the mental disorder that can be caused by the use of the more dangerous drugs such as LSD or methamphetamine. There are inpatient treatment facilities established under the Commissioner of Mental Health. Voluntary admission is provided for, but there is also a provision for commitment by the court for a period not exceeding twenty-four months.

Research has shown that symptoms induced by LSD can recur weeks or even months after ingestion, (See Chapter I, p.6) and emergency psychiatric treatment may be necessary to deal with a recurring drug-induced psychosis. Connecticut law provides that:

> any person who has suddenly become in need of care and treatment in a hospital for mental illness for a psychiatric disorder other than drug dependence

> or for drug dependence when his condition is acute and creates a pronounced danger to himself or to the community may be confined in such a hospital, either public or private, under an emergency certificate as here-in-after provided, for not more than thirty days without order of any court. . . [10]

As previously mentioned, medical treatment and education should be the primary focus of legislative control of possession and usage of substances capable of abuse. Regulation of the drug itself should be relegated to the areas of: manufacture, distribution, and general traffic. What is most needed is a means by which first offenders can have their prosecutions suspended by a court in appropriate circumstances, while they undergo out-patient or in-patient treatment as indicated. As for multiple offenders, it may be that the individual needs the controls which only a jail can provide, and if a person is not mentally disturbed and insists on using drugs, society may justifiably decide to punish such behavior. Every effort should be made, however, to return the person to useful functioning without the use of the prison cell.[11]

FEDERAL NARCOTIC AND DANGEROUS DRUG LAWS.

Five (5) principal statutes are designed to insure an adequate supply of narcotics for medical and scientific needs, while at the same time to curb abuse of narcotic drugs and marijuana. [12] For a more detailed account of federal laws regarding narcotics and drugs, the reader is referred to Appendix F.

HARRISON NARCOTIC ACT (1914). The Harrison Narcotic Act sets up the machinery for distribution of narcotic drugs within the country. Under the law, all persons who import, manufacture, produce, compound, sell, deal in, dispose or transfer narcotic drugs must be registered and pay a graduated occupational tax. The law also imposes a commodity tax upon narcotic drugs produced in or imported into the United States and sold or removed for consumption of sales.

Under the Harrison Act, sales or transfers of narcotic drugs must be recorded on an official order form. However, the transfer of narcotic drugs from a qualified practitioner to his patient and the sale of these drugs from a pharmacist to a patient with a lawfully written doctor's prescription are exceptions to this requirement.

NARCOTIC DRUGS IMPORT AND EXPORT ACT (1922). The Narcotic Drugs Import and Export Act authorizes the import of crude opium and coca leaves for medical and scientific needs in the United States. Import of other narcotic drugs is prohibited. Manufactured drugs and preparations may be exported under a rigid system of controls to assure that the drugs are used for medical needs only in the country of destination.

MARIJUANA TAX ACT (1937). The Marijuana Tax Act requires all persons who import, manufacture, produce, compound, sell, deal in, dispense, prescribe, administer, or give away marijuana to register and pay a graduated occupational tax. No commodity tax is imposed on this drug. However, a tax is imposed upon all transfers of marijuana at the rate of $1 per ounce; a fraction of an ounce, if the transfer is made to a taxpayer registered under the Act.

NARCOTICS MANUFACTURING ACT (1960). The Narcotics Manufacturing Act of 1960 develops a system of licensing manufacturers to produce narcotic drugs. It also provides a method to set manufacturing quotas for the basic classes of narcotic drugs, both natural and synthetic, insuring that an adequate supply of each drug will be available for medicine and science.

DRUG ABUSE CONTROL AMENDMENTS. Three groups of dangerous drugs -- depressants, stimulants and hallucinogens -- are controlled by the Drug Abuse Control Amendments to the Federal Food, Drug and Cosmetic Act passed in 1965 and amended in 1968. These amendments provide for stronger regulations in manufacture, distribution, delivery and possession and strong criminal penalties against persons who deal in these drugs illegally. All registered manufacturers, processors, and their suppliers, wholesaler druggists, pharmacies, hospitals, clinics, public health agencies, and research laboratories must take an inventory, keep accurate records of receipts and sales of these drugs and make their records available to Bureau of Narcotics and Dangerous Drugs agents for examination. No prescription for a controlled drug older than six months can be filled nor can refills be made more than five times in the six-month period.

PROPOSED FEDERAL DRUG ABUSE LEGISLATION.

Senator Harold Hughes of Iowa, Chairman of the Special Senate Subcommittee on Alcoholism and Narcotics, introduced in March 1970, S. 3562, the Federal Drug Abuse and Drug Dependence Prevention, Treatment and Rehabilitation Act of 1970. The legislation would establish the administrative structure and authorization for an unprecedented, massive, across-the-board federal attack on the drug epidemic in this country, from a prevention, treatment, and rehabilitation point of view. More specifically, the legislation would:

> . . .establish within the public health service of the Department of Health, Education, and Welfare, a drug abuse prevention, treatment, and rehabilitation administration, which would have a completely comprehensive range of responsibilities with respect to the prevention, treatment, and rehabilitation of drug dependents and drug abusers, in accordance with a specific and comprehensive drug abuse and drug dependence control plan which would be drawn up and carried out by the newly created administration and would be submitted annually to Congress for review;

replace present legislation governing treatment and rehabilitation services available to drug dependent persons charged with or convicted of violating federal criminal laws with updated and stronger legislation, which, while continuing the same basic policy of treatment and rehabilitation, would greatly expand the number of persons eligible for such treatment and rehabilitation and would make more definite the federal government's obligations to carry out that policy;

require the establishment of prevention programs and the recognition and encouragement of treatment and rehabilitation programs for all federal employees and members of the armed services. It would also require the establishment of treatment and rehabilitation programs for veterans and the inclusion of drug abuse and drug dependence in group health and disability insurance policies made available to federal employees;

require the recognition of drug abuse and drug dependence as a significant health problem in a broad range of programs affecting health matters, including vocational rehabilitation programs, the Economic Opportunity Act programs, welfare programs, highway safety planning programs, medicare, medicaid and social security;

authorize the Secretary of Health, Education, and Welfare to make grants to and enter into contracts with state and local organizations, agencies, institutions and individuals to carry out a comprehensive range of activities in the drug education, prevention, treatment and rehabilitation areas; and

establish an independent Secretary's advisory committee on drug abuse and drug dependence, appointed by the Secretary of Health, Education, and Welfare, to advise and consult with the newly created administration and to assist it to carry out the purposes of this Act; and would establish an intergovernmental coordinating council on drug abuse and drug dependence to assist the Secretary of Health, Education, and Welfare to coordinate all federal prevention, treatment, and rehabilitation efforts dealing with problems of drug dependence and drug abuse. [13]

PROPOSED MODEL FOR STATE-WIDE LEGISLATION.

The following statements are based on Michigan's Governor J. W. Milliken's February 19, 1970 "Special Message to the Legislature on Drug Dependence and Abuse." [14] His specific proposals for a comprehensive drug abuse program draw heavily on the recommendations of his special committee on drug dependence and abuse and on the contributions of the participants in the governor's conference on drug abuse.

OFFICE OF DRUG DEPENDENCE AND ABUSE. The creation of an office of drug dependence and abuse would: (1) Mount a coordinated educational and public information program to change attitudes, to make information about drug use and its consequences available to young people and the general public, and to improve the capacity of parents, teachers, and other professional groups to recognize and deal with this problem; (2) Work with the departments of mental health, public health, social services, corrections, education, state police and licensing and regulation and with private agencies to develop a comprehensive approach toward prevention and control of drug dependence and the diagnosis, treatment and control of drug-dependent persons and evaluate program results; (3) Encourage and stimulate effective program development to get maximum use of all available sources of federal funding; (4) Undertake a complete re-examination of Michigan's laws concerning dangerous drugs and present proposed statutory revisions a year from now; and (5) Plan for the expenditure of public funds allocated for drug abuse, including control, education, treatment, and rehabilitation activities and make recommendations to the governor and the legislature on all budget and grant requests affecting this program.

PROGRAMS FOR DRUG TRAFFIC CONTROL. An essential element in a comprehensive drug program is adequate control of the distribution of all dangerous drugs: legal and illegal. Accordingly, the following improvements in the control of drug traffic were recommended: (1) Return discretion to trial judges in the imposition of sentences for narcotics and drug laws violations; (2) Enact legislation to (a) authorize inspection of drug records by agents of the department of licensing and regulation; (b) license out-of-state drug manufacturers, wholesalers, or distributors that do business in Michigan; (c) tighten regulation of phone drug orders; and (d) prohibit the filling of narcotic and dangerous drug prescriptions by mail; (3) Create a state commission on investigations to provide Michigan with a new tool in the campaign to eliminate organized crime's traffic in narcotics; (4) Expand Michigan's crime laboratory capacity; (5) Strengthen the narcotics unit of the Michigan State Police; (6) Enact the proposed State-Controlled Dangerous Substances Act which would establish state regulation of dangerous substances consistent with proposed federal legislation; and (7) Support legislation placing marijuana in the dangerous drug classification in the penal laws.

PROGRAMS FOR DRUG ABUSE EDUCATION. Public education must neither reinforce present myths and misconceptions about drugs nor simply tell true (but often unrepresentative) horror stories about drugs. In launching a public education and public information effort, the following initial steps were proposed: (1) Coordinate all state information programs on dangerous drugs by the office of drug dependence and abuse, and develop programs to involve the maximum participation and assistance of the press and mass media to provide the most effective drug information program possible; (2) Implement critical health problems education programs in every school in the state at the earliest grade level feasible. The program should provide students with know-

ledge of the nature of drugs, of the immediate and long-range effects of particular substances, and of the hazards that drug abuse poses for individuals and for society; (3) Strengthen teacher training and other professional programs at the college/university level to include drug and drug abuse elements in core curricula; (4) Develop education programs, seminars and workshops to provide adults, primarily parents, with access to accurate information regarding drugs; (5) Encourage the development of neighborhood information centers in high risk areas that can bring to the current and potential drug user education and counseling services; and (6) Design seminars, workshops, and other training opportunities to improve the capacity of professionals -- teachers, social workers, nurses, pharmacists, physicians -- to work with potential and actual drug abusers.

PROGRAMS FOR TREATMENT AND REHABILITATION. No matter how effective drug prevention and drug control programs are, it must be realized that there will always be some individuals who, for a variety of reasons, will become addicted to narcotics or will become dependent on or abuse other dangerous drugs. Treating these individuals and providing adequate rehabilitation is perhaps the most difficult, and the most expensive, aspect of a comprehensive drug program.

An effective rehabilitation program requires not only withdrawal and detoxification, but after-care and supportive services, adequate provision for job training, education and counseling and sheltered housing if the drug-dependent person is to have a chance to function normally and productively. The following recommendations were offered for initial state action toward the establishment of a comprehensive drug treatment and rehabilitation program: (1) The need for funds for an experimental and demonstration vocational rehabilitation program for drug-dependent persons to move these persons back into the mainstream of productive economic life; (2) Expand treatment therapy programs for emotionally disturbed minors dependent on drugs; (3) Develop rehabilitation programs for drug users convicted of crimes, particularly youthful offenders; (4) Appoint a drug-control counselor, to each county, to develop countywide programs under the general direction of an appropriate agency of the state; (5) A study of regulations concerning the use of methadone in those states in which its use has been adopted; which insure control of its distribution and for new methadone regulations to prevent its diversion yet not constrain treatment nor require unrealistic staffing or control measures; (6) Appoint a citizen's advisory committee on drug abuse whose assignment, in part, would be to establish criteria to certify crisis centers and other community treatment or referral organizations; and (7) The need for close cooperation with all state departments in planning for the development of community-based treatment and rehabilitation services.

FOOTNOTES

[1]Neil L. Chayet, Legal Aspects of Drug Abuse, (New York: Appleton, Century and Crofts), p. 1, Excerpt.

[2]Ibid.

[3]Ibid.

[4]Christopher Cory and Raymond Godfrey, A TIME Guide to Drugs and the Young," The TIME Education Program, (June, 1970), p. 13.

[5]Ibid.

[6]Ibid.

[7]Ibid.

[8]Chayet, op. cit., p. 2.

[9]Ibid., p. 4.

[10]Ibid.

[11]Ibid.

[12]"Drugs in the Schools," Compact, IV, No. 3 (June, 1970), p. 44.

[13]Ibid., p. 24.

[14]Ibid., p. 18.

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APPENDICES

APPENDIX A

DEFINITION OF TERMS

DEFINITION OF TERMS

* ADDICTION. "A state of periodic or chronic intoxication produced by the repeated consumption of a drug and involves tolerance, psychological dependence, usually physical dependence, an overwhelming compulsion to continue using the drug, and detrimental effects on both the individual and society."[1]

DANGEROUS DRUGS. "A legal term which applies specifically to barbiturates, amphetamines, and other drugs (except the narcotics) which are officially determined to have a potential for abuse because of their depressant, stimulant, or hallucinogenic effect on man." NOTE: Federal control of the dangerous drugs is under the jurisdiction of the Food and Drug Administration, whereas, federal control of the narcotics is under the jurisdiction of the Bureau of Narcotic Enforcement of the United States Treasury Department."[2]

DESIRE. "A persistent, but not overpowering, wish for a drug to an undeniable compulsion to take the drug and to obtain it by any means."[3]

DRUG. "A medicine or a substance used in the making of medicine and, when used within the context of the illegal use of drugs, has been interchanged freely with the term 'narcotics.'"[4]

DRUG ABUSE. "The illegal self-administration of drugs, narcotics, chemicals, and other substances to the possible detriment of the individual, of society, or of both."[5]

DRUG ABUSE EDUCATION. "Reasonably accurate information on abused or illegal drugs, conveyed via a psychological principle (or force), and designed to change individuals' knowledge, attitudes, or behavior in a direction desired by the educator."[6]

* DRUG DEPENDENCE. "A state arising from repeated administration of a drug on a periodic or continuous basis." According to this definition, the characteristics of dependence vary with the agent involved (i.e., drug dependence of the morphine type, drug dependence of the cocaine type, drug dependence of the barbiturate type, drug dependence of the marijuana type, drug dependence of the amphetamine type, drug dependence of the alcohol type."[7]

* HABITUATION. "A condition, resulting from the repeated consumption of a drug, which involves little or no evidence of tolerance, some psychological dependence, no physical dependence, and a desire (but not a compulsion) to continue taking the drug for the feeling of well-being that it engenders."[8]

PHYSICAL DEPENDENCE. "A condition in which the body has adjusted to the presence of a drug and, when forced to function without the drug, reacts with a characteristic illness, called 'abstinence syndrome' or 'withdrawal illness.'"[9]

PSYCHIC DEPENDENCE. "The individual who receives satisfaction from his first use of a drug tends to make repeated use of the drug. Through continued repetition he may find it necessary to utilize the drug as an instrument in his adjustment to life, relying upon it for fulfillment which others achieve without the help of drugs."[10]

TOLERANCE. "A condition in which body cells protect themselves against toxic substances by developing resistance to them. Tolerance is manifested when repeated doses of the same amount of a drug become diminishingly effective and progressively larger doses are required to secure the desired effect."[11]

* The language of laws (international, national, and local) which governs drugs subject to abuse encompasses the terms "addiction" and "habituation." As it would be difficult to set these laws aside, it appears that all three terms become part of drug abuse terminology, with "drug dependence" being favored by medically oriented groups and "addiction" and "habituation" being favored in legislative and law enforcement circles.

APPENDIX B

ANNOTATED BIBLIOGRAPHY: SELECTED READINGS IN DRUG ABUSE EDUCATION

ANNOTATED BIBLIOGRAPHY: SELECTED READINGS IN DRUG ABUSE EDUCATION[12]

BOOKS.

Alpert, R., Cohen, S., and Schiller, L. LSD. New York: New American Library, 1966. This book should help educators to obtain a balanced view of the present LSD controversy. Its pictorial presentations highlight the emotional nature of the LSD experience.

Ausebel, David P. Drug Addiction: Physiological, Psychological and Sociological Aspects. New York: Random House, 1958. This book contains many helpful insights into the various aspects of drug addiction.

Barber, Bernard. Drugs and Society. New York: Russell Sage Foundation, 1967. A book on the sociology of drugs which discusses therapeutic drugs, "religious" drugs and "addictive" drugs and points out that substances called drugs must be studied from the physiological, the psychological and social aspects. Includes material on the drug industry, testing of drugs, government control and supervision, police approaches vs the socio-medical.

Blakeslee, A. What You Should Know About Drugs and Narcotics. New York: Associated Press, 1969. A series of newspaper articles, published in a 48-page book.

Blum, Richard H. Drugs I: Society and Drugs. Drugs II: Students and Drugs. San Francisco: Jossey-Bass Publishers, 1969. These two volumes contain the results of eight years' research by Blum and his associates and include historical, cross-cultural, social and psychological studies on drug use and abuse. They are based on work covering over 200 cultures and 20,000 individual interviews and questionnaires.

_____. The Utopiates: The Use and Users of LSD-25. New York: Atherton Press, 1964. A major study of LSD use in a variety of settings, and of users and non-users. Contains chapters on the psychopharmacological, legal and social aspects of LSD.

Chein, Isidor, with the collaboration of Daniel M. Wilner. The Road to H: Narcotic, Delinquency and Social Policy. New York: Basic Books, 1964. A study of heroin use among different ethnical groups of teen-agers in New York. This book distinguishes four stages in involvement with drugs: experimentation, occasional use, habitual use and regular use with efforts to break the addiction.

Cohen, Sidney. The Drug Dilemma. New York: McGraw-Hill, 1968. Concise description of drug use, focusing on relationships between the agent, the host, and the setting. Drug abuse progenitors discussed. Excellent advise to parents and educators on dealing with drug problem.

_____. The Beyond Within: The LSD Story. New York: Altheneum, 1964. One of the early psychiatrists to explore the effects of LSD during the past ten years presents reports on "good trips" and "bad trips," discusses "good" uses and "bad" uses.

Curtis, Lindsay. Let's Talk About Drugs. Dallas: Tane Press, 1967. Written concisely and using a question-answer approach, this booklet should appeal to youth. It discusses general aspects of marijuana and LSD abuse, glue-sniffing, as well as the misuse of barbiturates, amphetamines and tranquilzers.

De Ropp, Robert S. Drugs and the Mind. New York: Grove Press, 1957. A biochemist discusses the mental effects of chemicals in the brain and on the brain. The book is twelve years old but still generally valid.

Drug Abuse: A Manual for Law Enforcement Officers. Philadelphia: Smith, Kline and French Laboratories, 1966. Although this manual is designed for law officers, in it there are several sections which could be quite informative to teachers, especially those sections which deal with drug groups subject to abuse, the drug user, the illegal traffic in dangerous drugs and the drug industry's security methods.

Drug Abuse: A Reference for Teachers. Trenton: New Jersey State Department of Education, 1967. The chapter on "The Role of the School" provides excellent suggestions for incorporating an attack on drug abuse in the school's program.

Drug Abuse: A Source Book and Guide for Teachers. Sacramento: California State Department of Education, 1967. Although primarily designed for instructors in California, there are two excellent chapters on instruction in this source book. This guide also contains objective tests designed to measure the students knowledge of drug abuse information.

Drug Abuse: Escape to Nowhere. Philadelphia: Smith, Kline and French Laboratories, 1967. This excellent guide for educators discusses the drugs of abuse and their effects, the various methods of therapy for the drug abusers, the educational approaches that can be utilized and the problems of abuser identification.

Duncan, Tommie L. Understanding and Helping the Narcotic Addict. Englewood Cliffs: Prentice-Hall, 1966. A chaplain's experience and views on addicts, addiction, and how to help addicts.

Ebin, David (ed.). The Drug Experience. New York: Grove Press, 1965. First person accounts of addicts, writers, scientists and others regarding cannabis, opium, opiates, peyote, mushrooms and LSD.

Farber, S.M. and Wilson, R.H.L. (eds.). Conflict and Creativity: Control of the Mind, Part II. New York: McGraw-Hill, 1963. Articles by Isbell on the history of American attitudes toward addiction and by Beecher, Hollister and others on methodological problems in research on drugs.

Fort, Joel. The Pleasure Seekers: The Drug Crisis -- Youth and Society. Indianapolis and New York: The Bobbs-Merill Co., 1969. With remarkable insight one of the nation's leading authorities on mind altering substances relates their use to the alienation of youth and the problems this signals in our society.

Glaser, Daniel and O'Leary, Vincent. The Control and Treatment of Narcotic Use. Washington, D.c.: Government Printing Office, 1966. This booklet discusses the physiological effects of narcotic drugs, historical and psychological factors involved in narcotics abuse and the various types of treatment.

Goldsmith, Richard. The Poetry of Rock. Bantam Books, Inc., 1969. Discussion of rock music and reprints of 70 representative modern songs.

Gunther, Bernard. Sense Relaxation: Below Your Mind. Collier, Books, 1969. In few words and many photographs, Gunther describes the techniques he has used to produce drugless sensory turn-ons, and explains how they can be performed. Since one chapter makes several rather intimate suggestions, some teachers may wish not to recommend this to all students.

Harms, Ernest (ed.). Drug Addiction in Youth. Oxford: Pergamon Press, 1965. This volume, the results of the efforts of persons who have worked with young drug addicts, covers many of the major aspects of juvenile drug addiction in an informative manner. Different authorities have contributed to this volume, writing on topics such as: narcotic addiction among the newborn, psychopatheology of drug addiction, and religion and narcotic addiction among juveniles.

Hollander, Charles (ed.). Student Drug Involvement. Washington, D.C.: Government Printing Office, 1967. This publication deals with the history, sociology, psychopharmacology and legality of drug use as well as the student drug involvement.

Huxley, Aldous. The Doors of Perception and Heaven and Hell. New York: Harper and Row, 1956. In the 1940's researcher Humphrey Osmond gave Huxley some mescaline, precisely because he counted on Huxley's skill at describing his experiences in vivid detail. He did.

International Control of Narcotic Drugs. New York: United Nations Publications, 1965. This booklet describes the methods and scope of international narcotics control, the history leading to the present system of control, the types of drugs under international control and the suppression of illicit traffic in narcotic drugs.

Kelh, Lawrence. Drug Addiction: A Medical Problem. Springfield, Illinois: Charles T. Thomas Publishers, 1962. This book's purpose is to increase the reader's understanding of drug abuse and to encourage development of control and treatment programs. The whole book attempts to point out that drug abusers should not be treated as hardcore criminals, false propaganda should stop and drug dependency should be treated as a health problem.

Kluver, Heinrich. Mescal and Mechanisms of Hallucinations. Chicago: Phoenix Books, 1966. Mescaline, alkaloid present in buttons of a small cactus, mescal, as related to LSD.

Kreig, Margaret B. Green Medicine. Chicago: Rand McNally & Co., 1964. This book discusses the scientific interest in medicinal plants and the research in both laboratory and jungle for botanical drugs that cure.

_____. Black Market Medicine. Englewood Cliffs: Prentice-Hall, Inc., 1967. This book reveals the people who produce and distribute illegal pharmaceuticals, as well as affording a view of many of the undercover activities involved with drug abuse control.

Kron, Yves J. and Brown, Edward M. Mainlind to Nowhere -- The Making of a Heroin Addict. New York: Pantheon Books, 1965. Narrative of a young New York City addict, showing background, relation to others, history of addiction, crime, arrest, hospitalization, abstinence, and relapse.

Lamer, Jeremy (ed.). The Addict in the Street. New York: Grove Press, Inc., 1964. This book contains the first person stories of heroin addicts who live in constant threat of degradation, arrest and torture. It shows the wide gulf that exists between the addict's needs and desires and his own self-portrait.

Land, Herman W. What You Can Do About Drugs and Your Child. New York: Hart Publishing Co. Inc., 1969. Land concisely tells parents exactly what to do if they suspect or know their child is experimenting with drugs, and tells them better than anyone writing in the field. The appendix includes a list of where to go for help in every state.

Lindesmith, Alfred R. The Addict and the Law. Bloomington, Indiana: Indiana University Press, 1965. A discourse on the criminogenic aspects of drug laws and police practice with a plea for a new way of looking at and treating drug addicts.

Lin-Fu, Jane S. Neonatal Narcotic Addiction. Washington, D.C. Children's Bureau, 1967. This booklet contains a summary of information available on neonatal narcotic addiction, based on a review of literature.

Lingeman, Richard R. Drugs From A to Z Dictionary. New York: McGraw-Hill, 1969. This work will supply the reader with ten pages of the origin of drugs, their physical appearance, medical uses, with examples pulled out of popular literature of how they are abused and the fact that "lysergic acid diethylamide" for example, is called "acid" or LSD.

Livingston, Robert. Narcotic Drug Addiction Problems. Proceedings of the Symposium on the History of Narcotic Drug Addiction Problems, March 27-28, 1958, Bethesda, Maryland. Washington, D.C.: Government Printing Office, 1958. While reading this book, the reader must remember to keep the content in historical perspective. Some of the material gives quite a good insight into various facets of the drug addiction problem.

Louria, Donald B. Nightmare Drugs. New York: Pocket Books, Inc., 1966. Written by a physician, this paperback discusses stimulants, heroin, sedatives, tranquilizers and hallucinogens, as well as addiction and the laws.

_____. The Drug Scene. New York: McGraw-Hill, 1968. An extensive and critical analysis of the entire drug situation from a medical doctor who is also a teacher. The tenor of the work is a warning from factual example. It's most useful sections -- the first two chapters -- cover the reasons for the problem and its extent.

Masters, R. E. L. and Houston, Jean. The Varieties of Psychedelic Experience. New York: Holt, Rinehart and Winston, 1966. Analysis of data based on first-hand observations of 206 drug sessions and interviews with an additional 214 subjects who took the drug in a variety of settings. Discussion of the effects of drug taking with respect to body image, perceptions of other persons, repressed experiences, symbolism, religious and mystical experience.

Matthews, Jay D. Narcotics Legislation: Its Effects on Narcotics Traffic. Elizabethtown, Pennsylvania: Unpublished work, 1968. A student's study of the effect of legislation on the narcotics traffic.

Mauer, David W., and Vogel, Victor H. Narcotics and Narcotics Addiction. Springfield, Illinois: Charles C. Thomas, 1962. (Second Edition) Book is written for police, judges, teachers, clergy, and others who can perform a prevention and control role.

_____. Narcotics and Narcotic Addiction. Springfield, Illinois. Charles C. Thomas, 1967. (Third Edition) This book is an attempt to describe the various drugs of addiction and to report on the physiological effects of these drugs. Some generalizations are made in reference to the social implications of addiction.

McGee, Richard A. New Approaches to Control and Treatment of Drug Abusers in California. New York: McGraw-Hill, 1965. The California program as of 1965.

Medicinal Narcotics. Washington, D.C.: Pharmaceutical Manufactures Association, 1965. This booklet describes the various governmental controls over narcotics, points out the cornerstone of medicinal narcotics control and stresses the need for uniformity in laws and terminology as the foundation for effective enforcement of regulations.

Narcotic Drug Addiction. Mental Health Monograph 2. Washington, D.C: Government Printing Office, 1965. This booklet covers many of the more important aspects of narcotics drug addiction.

Nowlis, Helen H. Drugs on the College Campus. New York: Anchor Books, Doubleday, 1967. An exhaustive appraisal in lay terminology which educators may find useful. It covers terminology, attitudes, chemistry, sociology, law, morality and education as they affect both the user and society. The book contains an annotated bibliography, a glossary, and Dr. Joel Fort's comprehensive chart on drugs and their effects.

O'Donnell, John A. The Relapse Rate in Narcotic Addiction: A Critique of Follow-up Studies. New York: McGraw-Hill, 1965. A study of eleven relapse-rate studies, showing the factors and the experience.

_____. Narcotics Addiction. New York: Harper & Row, 1966. Presents the major contending viewpoints on causes, effects, treatment programs and trends.

Pollard, John C. and Uhr, Leonard. Drugs and Phantasy, the Effects of LSD, Psilocybin and Sernyl Experiences. Each Student subject relates his experiences.

Prevention and Control of Narcotic Addiction. Washington, D.C.: Government Printing Office, 1966. Discussion of the historical aspects of the control of narcotic abuse with a view toward establishing two points: (1) compulsory hospitalization of narcotic abusers; and (2) effective policing.

Psychedelics and the College Student. Princeton: Princeton University Press, 1967. This booklet was written by college students for college students. Although the information is not presented from a professional viewpoint of psychedelics, it does point out that the drug question can no longer be avoided.

Psychosocial Aspects of Drug-Taking. Proceedings of a conference held at University College, London. Oxford: Pergamon Press, 1965. Although this booklet discusses the drug dependency situation in England, some of the information on causes and motives of drug abuse and the role of education in preventing drug abuse may be helpful to the teacher.

Robinson, M. Nyswander. The Drug Addict as Patient. New York: Grune and Stratton, 1965. Physicians who have treated narcotic addicts describe various approaches used in private practice and institutional care.

Ropp, Robert S. Drugs and the Mind. New York: Grove Press, 1957. A biochemist discusses the mental effects of chemicals in the brain and on the brain. Although the book is not of recent vintage, it is still generally valid.

Roszak, Theodore. The Making of a Counter Culture. Garden City, New York: Doubleday & Co., Inc. 1969. Both in analytical terms and in the words of New Left authors to whom the youth are drawn, Roszak explains why youth is turning on and dropping out of conventional society. An excellent introduction to the cultural context of drug use by the young.

Saltman, Jules. What We Can Do About Drug Abuse. Public Affairs Pamphlet No. 390. New York: Public Affairs Committee, Inc., 1966. This booklet shows that the many-faceted problem of drug abuse calls for many solutions. It makes interesting as well as informative reading for students.

Schur, Edwin M. Crimes Without Victims: Deviant Behavior and Public Policy. Englewood Cliffs: Prentice-Hall, 1965. The classic plea for attention to public policy concerning abortion, homosexuality and drug-taking. Shows that drug addicts have to stay close to their sources of supply and thus create a sub-culture or community.

Services for the Prevention and Treatment of Dependence on Alcohol and Other Drugs. Fourteenth Report of the WHO Expert Committee on Mental Health. World Health Organization Technical Report, Series No. 363. Geneva: World Health Organization, 1967. This report discusses the problems of dependence on drugs, the types of programs needed to combat drug dependence and the areas of research that still need to be explored.

Simmons, Jerry L. and Winograd, Barry. It's Happening. Hollywood, California: Brandon House, 1966. This sociological study of the goals, ideals and activities of the affluent college drug users is a "sub-cultural" study written for the layman.

Solomon, David (ed.). The Marijuana Papers. Indianapolis, Indiana: Bobbs-Merrill Co., 1966. Reprint of some classic and out-of-print papers dealing with marijuana -- the historical, sociological and cultural; the literary and imaginative; and the scientific aspects.

_____. LSD: The Consciousness Expanding Drug. New York: G.P. Putnam & Sons, 1964. Reprinting of 15 papers on LSD by Huxley, Osmond, Leary, Kast, Unger et. al.

Task Force Report: Narcotics and Drug Abuse. Washington, D.C.: Government Printing Office, 1967. This report contains the findings and recommendations relating to narcotics and drug abuse made by the President's Commission on Law Enforcement and Administration of Justice in The Challenge of Crime in a Free Society. It also contains much information on mind-altering drugs relative to dangerous behavior and proposals for dangerous drug legislation.

Taylor, Norman. Narcotics -- Nature's Dangerous Gifts. New York: Delta Publishing Co., 1963. Despite the misleading title, a sound lay description of many of the "mind-altering drugs.

Totman, Ruth., Gertrude Lewis and Ruth Byler. Teach Us What We Want To Know. New York: Mental Health Materials Center, Inc., 1969. Report of a survey on health interests, concerns and problems of 5,000 students in selected schools from kindergarten through grade twelve.

Vogel, Victor H. and Virginia E. Facts About Narcotics and Other Dangerous Drugs. Chicago: Science Research Associates, Inc., 1967. This booklet contains a storehouse of information on the different types of drugs and their effects.

Wilkerson, David. Twelve Angels From Hell. Westwood, New Jersey: Fleming H. Revell Co., 1965. This book illustrates the personalities of twelve different hard-core drug addicts and depicts the changes that occurred in their lives as a result of spiritual experiences.

Wilkerson, David with John and Elizabeth Sherill. The Cross and the Switchblade. Westwood, New Jersey: Fleming H. Revell Co., 1963. Although this book is not primarily concerned with drug abuse, it does afford the reader a view of the physical and emotional environment of the drug abuser in the "asphalt jungle." It also stresses the necessity for demonstrating love for the adolescents who abuse drugs.

Wilner, Daniel M. and Kassebaum, Gene G. (eds.). Narcotics. New York: McGraw-Hill Co., 1965. This volume discusses the problems of drug use from the perspective of an epidemiologic model of the interaction of host (drug dependent personality), agent (pharmacological substance abused) and the environment which promotes drug abuse.

Winick, Charles. The Narcotic Addiction Problem. New York: The American Social Health Association, n.d. This booklet is a statement of the narcotic addiction problem in the United States and a brief presentation of the program that the American Social Health Association has initiated in order to combat drug abuse.

Winick, Charles and Jacob Goldstein. The Glue-Sniffing Problem. New York: The American Social Health Assocation, n.d. This booklet describes the practice of glue-sniffing, its effects, its relationship to drug dependence and some etiological factors involved.

Yablonsky, Lewis. The Tunnel Back. New York: Macmillan & Company, 1965. A description of Synanon's methods of treatment for drug addiction.

PERIODICALS.

"Addicted!" Good Housekeeping. CLXIV (May, 1967), 12+. A personal narrative of a woman who became dependent upon diet pills. This article should assist the student in understanding the dangers involved in abusing prescription drugs.

Anslinger, Harry J. "Narcotic Addiction As Seen by the Law-Enforcement Officer," Federal Probation, XXI (June, 1957), 34-41. A discussion of addiction's relation to the other crimes by a former Commissioner of the Bureau of Narcotics.

"A Town in Trouble," Life. (March 21, 1969). One of the few examples of a community that admitted having a drug problem and then did something effective to improve the situation.

Ball, J.C., W.M. Bates and J.A. O'Donnell. "Characteristics of Hospitalized Narcotic Addicts," Health, Education & Welfare Indicators. (March, 1966), 1-10. A view of addicts based upon inmates of the United States Public Health Service Hospitals in Lexington, Kentucky and Fort Worth, Texas.

Becker, Howard S. "History, Culture and Subjective Experience: An Exploration of the Social Bases of Drug-Induced Experiences," Journal of Health and Human Behavior. VIII, No. 3 (September, 1967), 163-176. This article develops a model based on cultural and social organization in an effort to explain the incidence of drug-induced psychoses, especially as related to LSD and marijuana.

Berlinger, Arthur K. "The Helping Process in a Hospital for Narcotic Addicts," Federal Probation. XXVI (September, 1962), 57-62. Discussion of hospital treatment of sentenced, probationary, and voluntary addicts.

Bewley, T.H. "Some Social, Psychological and Environmental Factors Associated with Drug Dependence," The Health Education Journal. XXVI (May, 1967), 60-66. This article discusses the social organization of drug taking, the personalities of addicts, the environment of addicts and the relationship of drug addiction to delinquency.

"Blacks Declare War On Dope," Ebony. XXV, No. 8 (June, 1970), 31-38&40. An article which reflects the fact that the police and government inaction prods New Yorkers to launch their own attack on narcotics.

Bloomquist, Edward R. "What Makes Teen Try Dope?" Parents' Magazine. (February, 1960). This article describes methods parents can utilize to help their children avoid drug abuse.

_____. "Let's Think Twice About 'Free' Narcotics," GP. XXI, No. 5 (May, 1960), 156-162 & XXI, No. 6 (June, 1960), 149-155. These two articles attack the idea that "free" narcotics should be distributed to addicts. A comparison is made between the so-called "British System" and the American way of handling addicts.

Brill, Leon. "Drug Abuse as a Social Problem," International Journal Of The Addictions. I, No. 2 (June, 1966). This paper highlights the sociological parameters of the addiction problem as well as the dramatic changes in perspective which have occurred in recent years.

Brill, Henry and Granville W. Larimore. "Second On-Site Study of the British Narcotic System," NACC Reprints. (June, 1967). This article points out the current situation on drug addiction in Britain and the modifications that are occurring in the "British System."

Brodsky, Philip. "Drug Plant Inspection," Food & Drug Administration Papers. (May, 1967), 7-14. This article describes what an FDA inspector looks for when he is inspecting a pharmaceutical manufacturing plant.

Bulletin on Narcotics. A bimonthly publication of the United Nations, New York. It depicts the narcotic problem on the international level.

Canepa, Giacomo. "La Necessita Curativa Del Tossicomane Nei Suoi Aspetti Giuridici E Medico-Criminologici," La Scuola Positiva. LXX, No. 2 (1965), 268-277. This article highlights the Italian experience under the 1954 legislation.

Chapman, Kenneth W., M.D. "Drug Addiction: The General Problem," Federal Probation. XX, No. 3 (September, 1956), 39-44. A summary of the state-of-the-art as of 1956 as to the number of addicts, their characteristics, their similarities and differences, and the nature of the drug traffic.

Carner, Charles. "Surprise Inside: Strange Effects of Drugs," Today's Health. (April, 1967), 57-59+. This article points out how drugs purchased OTC (over-the-counter) can lead to serious complications for persons who misuse them.

Caruanta, S. "Drugs -- A Social, Medical or Educational Problem?" The Health Education Journal. XXV (November, 1966), 184-191. This article discusses the various types of drug dependence, the personality of the drug-taking adolescent, the various groups of drugs abused and the role of health education in preventing an actual drug abuse situation.

Casselman, Bernard W. "You Cannot Be a Drug Addict Without Really Trying," Diseases of the Nervous System. XXV (March, 1964), 161-163. This article advocates seeking the causes of drug addiction so that preventive measures can be applied.

"Clinical Testing: Synopsis of the New Drug Regulations," FDA Papers, (March, 1967), 21-25. An explanation of regulations involved with clinical testing of new drugs.

Cohen, Allan Y. "Acid is Not as Advertised," American Red Cross Journal, XLIV, No. 3 (December, 1967), 18-19. A former associate of Dr. Timothy Leary explains why he stopped using LSD.

Cohen, Maimon M., Kurt Hirschborn and William A. Frosch. "In Vivo and In Vitro Chromosomal Damage Induced by LSD-25," The New England Journal of Medicine, CCLXXVII, No. 20 (November 16, 1967), 1043. A report of a study which convinced the authors of this article that the use of LSD causes a higher incidence of chromatid breakage than the non-use of LSD.

Cory, Christopher and Raymond Godfrey, "A TIME Guide to Drugs and the Young," The TIME Education Program, (June, 1970), 1-23. A comprehensive presentation of drug education techniques that includes discussion on the following: patterns of drug use; reasons for drug use; drugs and their dangers; drug laws; guidelines for discussion, prevention and early treatment; and suggestions for the classroom.

Curtis, Lindsay R. "LSD," Listen, XXI, No. 2 (February, 1968), 5-6. This article, written by a physician to young people, summarizes what is known about psychedelics.

"Dependence on Barbiturates and Other Sedative Drugs," Journal of the American Medical Association, CXCIII, No. 8 (August 23, 1965), 673-677. One of the series of statements regarding drug dependence, this article was prepared by the AMA Committee on Alcoholism and Addiction.

"Dependence on Cannabis (Marijuana)," Journal of the American Medical Association, CCI, No. 6 (August 7, 1967), 368-371. One of the series of statements regarding drug dependence, this article was prepared by the AMA Comm. on Alcoholism and Drug Dependence.

"Dependence on Amphetamines and other Stimulant Drugs," Journal of the American Medical Association, CXCVII, No. 12 (September 19, 1966), 1023-1027. Prepared by the AMA Committee on Alcoholism and Addiction, this statement is one in a series on drug dependence.

"Dependence on LSD and other Hallucinogenic Drugs," Journal of the American Medical Association, CCII, No. 1 (October 2, 1967), 47-50. One of the series of statements regarding drug dependence, this article was prepared by the AMA Committee on Alcoholism and Drug Dependence and the Council on Mental Health.

Dole, Vincent P. and Alan Warner. "Evaluation of Narcotics Treatment Programs," American Journal of Public Health, LVII, No. 11 (November, 1967), 200-208. This article points to the chaotic condition of the present system of reporting of narcotics treatment programs. It also contains a rather extensive selected bibliography on narcotic addiction treatment from 1960-1966.

"Drugs," Health Information Digest, XI, No. 2 (July, 1967), 78-87. Interesting highlights from 14 recent articles on many aspects of drugs such as: clinical impressions of drug abuses, legal actions against addicts and personality of the drug abuser.

"Drugs," World Health, (July, 1967), 1-40. An excellent pictorial portrayal of the problems associated with drug abuse on the international level. This article takes a comprehensive and quite interesting look at drugs.

"Drugs and the Educational Antidote," Nation's Schools, LXXXV, No. 4 (April, 1970), 49-53. Once limited almost entirely to urban ghetto and poverty areas, drug abuse became, in the mid-60's a national problem of American youth. The impression one gets about drug education programs, the article reports, is that school districts are all looking for solutions, are trying ideas here and there, and are reluctant to publicize what they are doing because they're not certain that they are doing the right thing.

"Drugs and the Young," TIME, (September 26, 1969). Cover story on the so-called "pop" drugs taken by the young.

"Drugs In The Schools," Compact, IV, No. 3 (June, 1970), 1-50. This issue contains a wide variety of informative material on drugs and narcotics and is directed toward state governors, legislators and educators.

"Drug Abuse," Journal of the American Pharmaceutical Association, LVIII, No. 1 (January, 1968). Much of this issue is devoted to drug abuse. The drugs of abuse, a history of drug abuse, psychotamimetic agents, and the pharmacist's role in drug abuse education are discussed. Several featurettes on drugs are also included.

Drug Dependence, Published at random intervals by the National Clearinghouse for Mental Health Information, this periodical is addressed to the scientific and medical community and other concerned professionals. It contains selected items covering recent developments in the field and identifies citations to the current abstracts available from NCMHI.

"Drug Menace: How Serious?" U.S. News & World Report, LXVIII, No. 21 (May 25, 1970). An interview with John E. Ingersoll, Director, Federal Bureau of Narcotics.

Eddy, Nathan B., et. al. "Drug Dependence: Its Significance and Characteristics," Bulletin World Health Organization, XXXII (1965), 721-733. A description of the various types of drug dependence and the rationale behind the use of the term "drug dependence."

Garrett, Dan L. "Synanon: the Communiversity," Humanist, (September-October, 1965), 185-189. A vivid description of Synanon's philosophy, methods and psychology.

Glatt, M.M. "Problems Common to Alcoholism and Drug Dependence," WHO Chronicle, XXI, No. 7 (July, 1967), 293-302. This article discusses the similarities between dependence on alcohol and dependence on drugs especially in respect to etiological and developmental factors.

Goddard, James L. "Criminal Abuse of 'Dangerous Drugs'" The Forensic Quarterly, XLI, No. 3 (August, 1967). This article stresses that the drug abuse problem in the United States is not an easily solvable problem.

"Good Manufacturing Practice," FDA Papers, (April, 1967), 22-25. A description of FDA's activities to assure that good manufacturing practices are being implemented by pharmaceutical firms.

Guttman, Oscar. "The Psychodynamics of a Drug Addict," American Journal of Psychotheraphy, XIX, No. 4 (1965), 653-665. A psycho-analysts approach, which weaves addiction into the states of neurosis and psychosis, and relates it to the sexual developmental pattern, including especially homosexuality.

Halleck, Seymour M.D. "The Great Drug Education Hoax," The Progressive, (July, 1970), 30-33. A compelling article that suggests that current approaches to drug education may not discourage youth from experimenting with drugs and in addition may be expensive and ineffective distractions from an examination of the basic moral and political questions which may be the roots of the drug problem.

Harms, Ernest. "Remedies for Drug Abuse -- Right and Wrong," Adolescent, II, No. 5 (Spring, 1967), 1-4. This editorial stresses the need to understand the world of youth in order to obtain a proper perspective on what should be done to eradicate the deep impulses which lead to drug abuse.

International Journal of Addiction. A publication devoted to the scientific study of drug use and abuse. It is published semi-annually by the Institute for the Study of Drug Addiction.

Kelley, Larry. "Stoned Out Of Their Minds," Trenton, XLVI, No. 3 (March, 1970), 14-21. A provacative article on the prevalence of drug use in Mercer County, New Jersey and the ease with which drugs can be obtained if the price is right and you know where to go.

Kleber, Herbert D. "Student Use of Hallucinogens," Journal of the American College Health Association, XIV (1965), 109-117. This study of 21 college students attempted to learn more about students who abuse drugs, the patterns of abuse, and the effects that abuse had on the students' lives.

_____. "Prolonged Adverse Reactions from Unsupervised Use of Hallucinogenic Drugs," The Journal of Nervous and Mental Disease, I, No. 4 (1967), 308-319. This article reviews some of the factors that have brought about the drug fad and presents a report of five cases that have suffered adverse reactions from drug experimentation.

McCarthy, William T. "A Prosecutors Viewpoint on Narcotic Addiction," Federal Probation, VII (October-December, 1943), 23-27. A lawyer's approach, based upon the statutory definition in the Act of Congress of January 19, 1929 establishing Public Health Service Hospitals.

Messinger, Emanuel, and Arthur Zithrin. "A Statistical Study of Criminal Drug Addicts," Crime and Delinquency, XI, No. 3 (1965), 283-292. Statistics and analysis of personality and habits of drug addict files taken from psychiatric and other reports of the New York County (Manhattan) Division of the Supreme Court of New York.

Miller, Theodore J. "Drug Abuse Schools Find Some Answers," School Management, (April, 1970), 22-31. Of the many drug abuse prevention programs that have been devised, most have been instituted on a crash basis; most have centered in the schools; and most have failed. The article informs, however, that some school districts are fitting a few of the pieces together. It goes on to conclude that any successful drug prevention program depends largely on the ability to enlist the aid of students, teachers, and the adult community and even then, an impressive battle plan does not ensure victory.

Moskowitz, Ronald. "Leaving the Drug World Behind," American Education, VI, No. 1 (January-February, 1970), 3-5. Youth of the new anti-drug culture try an impromptu exercise in sensory awareness and communication by the Pacific.

"Narcotic Addiction," New York Medicine, XXI, No. 2 (1965), 3-8. Gives the official policy of New York Medical Society relating to civil commitment, rehabilitation centers, follow-up clinics, sentencing practices, and public education.

Nyswander, Marie, M.D., et. al. "The Treatment of Drug Addicts as Voluntary Out-patients: A Progress Report," American Journal of Orthopsychiatry, XXVIII (October, 1958), 714-727. Discussion of one year's experience with out-patient treatment of 70 voluntary patients by 30 psychoanalytically trained therapists.

Perlman, Sanuel. "Drug Use and Experience in an Urban College Population," American Journal of Orthopsychiatry, XXXVII, No. 2 (March, 1967), 297-299. College factors based on 2,270 seniors at Brooklyn College of the City University of New York.

Peterson, David M., Richard M. Yarvis, M.D., and Gerald M. Farkas. "The Federal Bureau of Prisons Treatment Program for Narcotic Addicts," Federal Probation, (1970), 35-40. The article discusses the general philosophy and overall organization of the treatment program and is designed to inform various professionals who work in the area of narcotic addiction about the program.

"Playboy Panel: The Drug Revolution," Playboy Magazine, (February, 1970), 1-17. Nine authorities debate the pleasures, penalties and hazards of drugs and narcotics.

Prosser, William L. "The Narcotic Problem," UCLA Law Review, I (June, 1954), 405-546. A comprehensive treatment having a nine-page bibliography that is especially useful in reviewing statutory bases in several States.

"Report of the Narcotic Committee of the Criminal Law Section of the American Bar Association," American Criminal Law Quarterly, IV, No. 3 (1966), 147-154. Discusses the need for relevant legislation.

Rice, Julius and Levi Cohen. "Narcotic Drug Addiction: One Year's Experiences at Pilgrim State Hospital," The Psychiatric Quarterly, XXXIX (1965), 457-465. Detoxification and rehabilitation under New York's Metcalf-Volker Act which allows convicted addicts to opt for hospitalization and treatment.

Robertson, J.P.S. and D. Walton. "Addiction to Analgesic Drugs: Resume of Research," British Psychological Society Working Party on Drug Addiction, No. 5 (1960). A medical doctor's approach, based upon addiction being essentially a role, and therefore the playing of the role defining addiction in a given case.

Sheehy, Gail. "Speed is of the Essence," New York, (July 21, 1969). Two chilling years in the life of "Pammy," a 23-year old who gradually becomes completely dependent upon methedrine.

Shelly, Joseph A. and Alexander Bassin. "Daytop Lodge: A New Treatment Approach for Drug Addicts," Corrective Psychiatry and Journal of Social Therapy, XI, No. 4 (1965), 186-195. A halfway house concept, using a new (to the addict) status system based on hard work, honesty, integrity, and concern for others.

Skousen, W. Cleon. "The 'Instant Insanity' Drugs," Law and Order, XV, No. 9 (September, 1967), 83-87. This paper describes the dangers of the abuse of LSD, as well as suggesting six steps to counter-attack the increasing prevalence of drug abuse.

Smith, Jean Paul. "LSD: The False Illusion," FDA Papers, (July-August, 1967), 10-18. The LSD problem is presented from a psychologist's point of view in this article.

Sutter, Allan G. "The World of the Righteous Dope Fiend," Issues in Criminology, II, No. 2 (Fall, 1966), 177-222. The author debunks theories of addiction, and finds it the domain of yet another sub-group who find status in membership.

The Attack on Narcotic Addiction and Drug Abuse, A publication devoted to publicize the activities of the New York State Addiction Control Commission and to explain various aspects of drug abuse.

"The Drug Takers," TIME-LIFE Book Report, (1965). Attempts to describe the extent of addiction and dependence, in a series of articles.

The International Journal of the Addictions, A publication of the Institute for the Study of Drug Addiction; it provides a world-wide forum of exchange among professionals participating in research, training, and treatment in the field of addictions and substance misuse. An International editorial board, comprised of members of the various medical professions, focuses on all facets of substance misuse -- drug, alcohol, tobacco and food.

"Treatment and Control for Narcotic Addicts," Correctional Review, (September-October, 1965), 37-39. California's two-phase system, and how it originated in a study commission's findings.

UN Bulletin on Narcotics, Official notices of reports of meetings and actions taken by United Nations, including World Health Organization, related to drugs. Contains original scientific research papers and review articles.

Ungerleider, J. Thomas and D. Fisher Duke. "The Problems of LSD-25 and Emotional Disorders," California Medicine, No. 106 (January, 1967), 49-55. A description of the physiological and psychological effects of LSD with information on the acute and chronic side effects noted among LSD users.

Weech, Alexander A. "The Narcotic Addict and 'The Street,'" Archives of General Psychiatry, XIV (March, 1966), 299-306. A study of the environment of the individual who is dependent upon drugs and the priority that peer activities have for him over family relationships.

Weissman, Rozanne. "Teacher Hang-ups: First Hurdle to Overcome in Drug Abuse Education," The Journal of Arkansas Education, XLII, No. 7 (April, 1970), 6-21. Working with the premise that before educating students about drug abuse, educators must first be educated to teach the subject. This article examines the thinking behind a unique drug education pilot project for educators sponsored by two NEA units and funded by the federal government.

Winick, Charles. "Drug Addiction and Crime," Current History, (June, 1967), 349-354. An authoritative discussion of the illegal distribution system of drugs and the effects of treatment programs, as well as an attempt to answer the question: "Does crime antedate addiction?"

_____. "The Life Cycle of the Narcotic Addict and of Addiction," Bulletin on Narcotics, XVI, No. 1 (1965), 1-11. Age is examined as a variable, and it is concluded that two-thirds of addicts spontaneously drop drugs due to hormonal or other factors related to increasing age.

Winick, Charles and Herbert Bynder. "Facilties for Treatment and Rehabilitation of Narcotic Drug Users and Addicts," American Journal of Public Health, LVII No. 6 (June, 1967), 1025-1033. This study attempted to determine the range and extent of existing programs for treatment and rehabilitation in the United States in respect to services provided and criteria of admission.

Winslow, Walker. "Synanon: An Application of the Reality Principle," The Municipal Court Review, IV No. 3 (1965), 18-20. Discusses the value shaping, group status, techniques of Synanon and its fifty-five per cent success ratio.

Wolff, Pablo Osvaldo. "Narcotic Addiction and Criminality," The Journal of Criminal Law and Criminology, XXXIV (September-October, 1943), 162-181. Distinguishes criminal addicts from stabilized addicts, accidental addicts, and natural addicts, and finds them almost hopeless as regards treatment. Discusses the relationship between addiction and other crimes.

Wylie, Evan LcLeod. "The Pills Drivers Shouldn't Take," Reader's Digest, XC (February, 1967), 83-85. A description of the ways that many medicinal drugs, especially when combined with alcohol, can render an individual unfit to drive an automobile.

Zellweger, Hans., John McDonald and Gisela Abbo. "Is Lysergic Acid Diethylamide a Teratogen?" The Lancet, II No. 7525 (November 18, 1967), 1066. This case report attempts to show a relationship between the use of LSD and birth deformity.

PAMPHLETS AND OTHERS.

A Guide to Illicit Drugs. New York: American Social Health Association, n.d. This chart describes the habit forming drugs, their slang names, their primary effects, their detection, and the dangers of abusing the drugs.

Barbiturates as Addicting Drugs. Washington, D.C.: United States Department of Health, Education & Welfare, 1965. This pamphlet points out the dangers of abusing barbiturates and the methods utilized to treat individuals who have taken two large doses of barbiturates.

Collection of Marijuana Papers. Washington, D.C.: Bureau of Narcotics, 1965. A collection of materials on different aspects of marijuana.

Don't Guess About Drugs When You Can Have The Facts. National Clearinghouse for Mental Health Information Publication #1006, Washington, D.C.: Government Printing Office, 1965. A description and catalogue of the current drug-abuse information-education materials available from the National Institute of Mental Health, including the current Advertising Council commercials.

Drug Abuse: The Empty Life. Philadelphia: Smith, Kline and French Laboratories, 1965. A brief description of various types of drugs and some characteristics of drug abusers.

Drugs: A TO Z. New York: Columbia Broadcasting System, Earl Ubell, Science Editor, 1970. This publication provides a description of the many drugs that are used and/or abused in our society today. The document is based on a series of television news broadcasts presented during the summer of 1970 by the local New York affiliate of CBS Network.

Drugs of Abuse. Reprint from Food and Drug Administration Papers, Washington, D.C.: Government Printing Office, July-August, 1967. Pictorial description of various types of stimulants, depressants and hallucinogens. It describes why the various drugs are taken and what symptoms an abuser whould exhibit when under the influence of these drugs.

Drugs and People...About Unhealthy Dependence. Toronto, Canada: Alcoholism and Drug Addiction Research Foundation of Ontario, n.d. This comic booklet gives an insight into why people abuse drugs. Because of its appeal, this booklet would be excellent for students.

Fact Sheets 1-7. Washington, D.C.: Bureau of Drug Abuse Control, Food and Drug Administration, 1967. These fact sheets provide information on the Drug Abuse Control Amendments of 1965, the illegal traffic in dangerous drugs, the drug abuser, depressants, hallucinogens, stimulants and controlled drugs.

Gardner, Craig. LSD Addict Who Took His Own Life. February 14, 1970. Recording prepared for Trenton Times Newspapers by the Public Affairs Department of WAAT Radio in Trenton, New Jersey through the courtesy of KUTV Television in Salt Lake City, Utah.

Hooked. New York: Information Materials Press, n.d. This comic booklet tells the story of what it is like to be hooked. Because of its appeal, this booklet would appear to be excellent for students.

International Narcotic Enforcement Officers Association, Sixth Annual Conference Report. September 26-October 1, 1965, Miami Beach, Florida. Discussion of international traffic, methods of law enforcement, and methods of treatment.

Jurgensen, Warren P., M.D. In-patient Treatment of the Narcotic Addict, Paper presented at the Chatham Conference on Perspectives on Narcotic Addiction, Chatham, Massachusetts, September 9-11, 1963, pp. 34-44.

Lindesmith, Alfred R. Basic Problems in the Social Psychology of Addiction and a Theory, Paper presented at the Chatham Conference on Perspectives on Narcotic Addiction, Chatham, Massachusetts, September 9-11, 1963, pp. 1-16. A social-psychologists approach, which focuses upon the behavior of an addict as the defining factor especially the craving for drugs and the tendency to relapse.

Living Death: The Truth About Drug Addiction. Washington, D.C.: Government Printing Office, 1965. This pamphlet contains many of the essential facts about drug addiction. May be used for student reading, especially as introductory material.

Narcotics - LSD - Marijuana - The Up and Down Drugs. Washington, D.C.: Government Printing Office, n.d. These flyers, produced by the National Institute of Mental Health, use questions and answers to describe each drug and to describe mood effects, physical effects, medical uses, misuses, and research.

Resource Book for Drug Abuse Education. United States Department of Health, Education and Welfare, Washington, D.C.: Government Printing Office, 1969. An excellent collection of do's and don'ts for teachers, including first-rate short essays on the youth culture, the psychology, pharmacology and sociology of drugs.

Selected Publications on Drug Dependence and Abuse. New York: American Social Health Association, n.d. A kit comprised of selected publications on drug dependence and abuse.

State of New Jersey. State Law Enforcement Program Assistance Agency, A Desk Book on Drug Abuse. Dissemination Document No. 5, Trenton, New Jersey: State of New Jersey, December, 1969. This document is one of a series of Dissemination Documents addressing itself to a topic of importance to the criminal justice system and to our society at large -- narcotic addiction. The document is considered as a primer in that it merely summarizes what one should have handy on the subject. It is called a "desk book" because it is hoped that recepients -- law enforcement officials, education personnel, clergy and community leaders will use it.

State of New York: Narcotic Addiction Control Commission Kit. Albany, New York, n.d. A kit comprised of information related to the control of drug addiction and the treatment and rehabilitation of drug addicts.

60 Minutes. Produced by CBS NEWS, II No. 21, Tuesday, June 16, 1970 10:00 - 11:00 P.M., EDT, with CBS NEWS Correspondents Harry Reasoner and Mike Wallace. Transcript of a segment of the program dealing with young Americans who have been apprehended and jailed in European countries for possessing or selling illegal drugs.

Statement On Student Use of Drugs. Prepared by the Ad Hoc Committee on Student Use of Drugs, National Association of Student Personnel Administrators, January, 1970. The statement encourages NASPA members to engage in discussion and action programs with local and state enforcement agencies, legislators and judges as they relate to drugs and drug education programs.

The Crutch That Cripples: Drug Dependence. Chicago, Illinois: Committee on Alcoholism and Drug Dependence, Council on Mental Health, American Medical Association, n.d. Brief pamphlet containing much information on dependence, medical uses of drugs, symptoms, where to get help and prevention of abuse.

The Public Interest: Economics and Criminal Enterprise. by Thomas C. Schelling, Spring, 1967. A now-famous presentation of the argument that Prohibition creates opportunities for organized crime.

Thinking About Drinking. Washington, D.C.: Government Printing Office, n.d. Produced by the National Institute of Mental Health and the Children's Bureau as a basis for discussion with young people of attitudes about drinking. It also reflects the latest findings in alcohol research.

APPENDIX C

A COMPILATION OF INSTRUCTIONAL MEDIA: DRUG ABUSE EDUCATION

FILMS. Since there is a difference of opinion on the effectiveness of the various instructional media listed, this listing does not constitute an endorsement of any material by the NEW JERSEY URBAN SCHOOLS DEVELOPMENT COUNCIL. It is recommended that anyone planning on using any instructional media for drug abuse education should review it prior to its intended use. The names and addresses of the producers and/or distributors are included in this listing to provide a source of information on rental and purchases.

BENNIES AND GOOFBALLS. (Produced by Food & Drug Administration, United States Department of Health, Education & Welfare. Free Loan Source: Public Health Service Audiovisual Facility, Atlanta, Georgia 30333, Attn: Distribution Unit. Purchase Source: Precision Film Laboratories, 21 W. 46th Street, New York 36, New York. Intended Audience: General. 1966, B&W, 20 minutes.)

Hollywood actor Paul Newman narrates this FDA report on: abuse of amphetamines and barbiturates, the nation-wide scope of the problem, and legal steps being taken to curb it. Four people -- including a truck driver who experienced hallucinations, a "pill-head" who suffered physical and mental deterioration, and a Death Row inmate who capped a five-state drug-fed crime wave with murder -- tell of their experiences. Former USFDA Commissioner James L. Goddard explains the effects of amphetamine and barbiturate abuse, and outlines the 1965 federal law and enforcement procedures.

BEYOND LSD. (Produced and directed by Paul Burnford. Medical Consultant, J. Thomas Ungerleider, M.D. Distributed by Film Associates of California, 11559 Santa Monica Blvd., Los Angeles 90025. Intended Audience: Junior & Senior High School Students & Adult. 1968, Color, 25 minutes.)

A group of anxious middle-class parents express their fears via a dramatization that long hair, strange clothing styles, raucous music signal the irreversible plunge of their children into a shadow life of LSD abuse, degradation and crime. They are reassured, by a neighborhood counselor, Dr. Wright, that this need not be so if the parents substitute reason, patience and understanding for hysteria, lies, petty niggling and rule by fiat. The doctor shows a filmed talk by UCLA Psychiatry Professor J. Thomas Ungerleider, M.D. who's message is to try to understand a teenager's struggle with his anger, his sexuality and his emerging identity. Drugs let him hide this struggle from himself, but adult sympathy can forestall his resources to such a refuge. Let drugs be discussed openly so they lose their appealing aura as forbidden fruit. In closing Dr. Wright emphasizes: "Communication can narrow the generation gap. Skip the non-essentials

in dealing with teenagers -- clothes, fads, hairstyles, eating habits, speech mannerisms. They have no basic importance and are certainly not worth endless arguments which only convince a youngster we can never understand him." According to the credits, production crew for this film was composed of teenagers and young adults.

DRUG ADDICTION. (Produced by Encyclopedia Brittanica Films, 2494 Teagarden Street, San Leandra, California, in cooperation with Juvenile Protective Association of Chicago, Illinois and the Weiboldt Foundation. Consultant, Andrew C. Ivy, PhD., M.D. Intended Audience: High School Students & Adults. 1951, B&W, 22 minutes.)

Opiates, marijuana and cocaine are described with their properties and effects on the human body depicted by animation. The film emphasizes the point that drug addiction is a crime problem and is dramatized by the story of "Marty Demelon." Marty is a handsome, dutiful youth who one day smokes a marijuana cigarette. He advances to sniffing heroin, graduates to mainlining and addiction, and ends in the grasp of a policeman after looting a hardware store. He is sent to the federal hospital at Lexington, Kentucky where he is cured of his addiction. Upon returning, however, he is tempted to return to the drug. "Against such pressures," the film declares, "local outpatient clinics, social agencies, the Church -- all are needed." It also urges larger law enforcement staffs, stringent penalties against narcotics peddlers, and increased efforts to widen knowledge about drugs, especially among young people.

DRUGS AND THE NERVOUS SYSTEM. (Produced by Churchill Films, 662 North Robertson Blvd., Los Angeles, California 90069. Free Loan Source: State of California Department of Public Health, Bureau of Health Education Film Library. Intended Audience: Junior & Senior High School Students & Adults. 1967, Color, 18 minutes.)

Animation is combined with photographic vignettes to illustrate the effects of various classes of drugs on the human body and mind. The use of aspirin to relieve pain is employed as a vehicle to introduce viewers to the nature of drugs and the workings of the nervous system. The film then discusses glue, stimulants (amphetamines), depressants (barbiturates), opium-derivates (morphine, codeine, heroin), marijuana and LSD. Therapeutic uses, effects sought by abusers and the results of abuse of each class of drugs are explained. At the conclusion the narrator queries: "What do you think about the character of young people who abuse drugs.? Are they more likely to be strong or weak? Are they more likely to be responsible? Mature? Are they likely to have problems? What do you think?"

ESCAPE TO NOWHERE. (Produced by Professional Arts, Inc., P.O. Box 8484, Universal City, California 91608 in cooperation with the San Mateo (California) Union High School District. Intended Audience: Senior High School & College Students. 1968, Color, 25 minutes.)

The camera travels with Debbie, a 16-year old addict, moving through her lonely world as she describes how she started on drugs and reveals the futility of her present existence.

FALSE FRIENDS. (Produced by Interfilm, Inc., in association with the Film Producer's Guild. Purchase Source: Sound Services Limited, 269 Kingston Road, Merton Park, London, S.W. 19, England. Intended Audience: General. Color, 10 minutes.)

Drug dependence is the subject of this cartoon produced for the World Health Organization (WHO) in London by G. Bucklandsmith. The story is told in words and pictures.

FIGHT OR FLIGHT. (Sponsored by the International Association of Chiefs of Police in Cooperation with the United States Bureau of Narcotics. Produced and distributed by J&F Productions, Inc., Suite 700, 1401 Walnut Street, Philadelphia 19102. Intended Audience: Junior & Senior High School Students. 1967, Color, 16 minutes.)

Reminiscences of former addicts now resident at New York State's Day Top Village rehabilitation center are interspersed with narration and illustrative vignettes. Emphasis is on the detrimental effects of heroin and LSD, with marijuana, "pills," alcohol and cough medicine being addressed as well. Viewers are warned against seeking resolution of adolescent and familial conflicts in drugs, against following the gang willy-nilly. The film points out drug abuse leads to crime, automobile accidents, death and running around without any clothes on. The sufferings of drug-users' families are recounted by a mother and a wife. One young ex-addict declares that "it's nonsense that pot and LSD aren't habit-forming, that they (users) can stop any time. It's just not that way. It never has been !" "To escape from life is easy," the narrator concludes. "These are the facts, whether we like them or not. It's up to everyone to make a decision. . . fight or flight!"

FROM RUNAWAY TO HIPPIE. (Produced by the Cinema Verite Company, 3116 16th Street, Room 27, San Francisco, California 94103, in cooperation with NBC News. Intended Audience: General. 1967, Color, 18 minutes.)

A documentary about the hippie movement, its squalor and drug-based way of life. Originally shown as three six-minute segments on the NBC television Huntley-Brinkley Report. The first segment records the action at a pair of teenage glue-sniffing parties in Dallas, Texas and interviews the mother of two participants. The second follows three of the Dallas subjects to San Francisco's Haight-Ashbury

hippie community, where they have migrated in search of LSD, et al. A love-in, an acid wedding, the parade of gawking tourists, and a crowded pad are depicted. The final segment discusses rural hippie communes, where compatible drop-outs return to nature, "sharing their rice, their beans, their hepatitis, their veneral disease." The impact of hippie culture on American modes and mores is noted, and the responsibility of the mass media for spreading it is ironically pointed out.

GOOF BALLS AND TEA. (Produced by the New Jersey Police Training Commission, 1100 Raymond Blvd., Newark, New Jersey 07100. Intended Audience: Law Enforcement Officers. Color, 32 minutes.)

A training film for law enforcement officers depicting general coverage of human involvement.

HARDSTUFF. (Produced by the New Jersey Police Training Commission. 1100 Raymond Blvd., Newark, New Jersey 07100. Intended Audience: Law Enforcement Officers. Color, 45 minutes.)

A training film for law enforcement officers depicting general coverage of human involvement.

HELLO AMERICA. (Produced by the Cinema Verite Company, 3116 16th Street, Room 27, San Francisco 94103. Produced by Johann Rush. Intended Audience: Teachers, Adults & Professionals. 1967, B&W, 29 minutes.)

The film depicts two parties in Dallas, Texas where teenagers sniff glue, and act drugged. The mother of two young glue-sniffers is interviewed -- she suspects but is not sure of her children's activities. According to the narrator, there are four major factors common to most glue-sniffers: they have too much free time without parental guidance; they are caught up in the mass hysteria surrounding rock music groups whose members are known drug users; they are aware that other teenagers are "turning on"; and they have nothing else to do and no other way to get "high." Unsatisfactory home life and parents who do not know where their children go or what they do are also cited.

HIDE AND SEEK. (Produced by the Center for Mass Communication of Columbia University Press, 440 W. 110th Street, New York, New York 10025. Produced and directed by Julian Krainin. Psychiatric Consultant, Dr. Ronald R. Fieve, Columbia University. Intended Audience: Junior & Senior High School & College Students. 1966, Color, 14 minutes.)

A teenage boy describes his life as a heroin addict while he is shown wandering the seedier streets of New York City. The youth begins with marijuana, tries heroin on a dare, ends up addicted, alienated from his father, cut off from the normal world. The film's theme is ex-

pressed in the statement: "I'm a louse because I keep lousing up my life. . .No body beats it (dope), you can't. . .Sometimes I think, 'Look what I lost'. . .I guess I missed a lot of beautiful things."

HOOKED. (Produced by Churchill Films, Inc., 662 N. Robertson Blvd., Los Angeles, California 90027. Intended Audience: Junior & Senior High School Students. 1967, B&W, 20 minutes.

Young ex-addicts tell of their experiences when using drugs: heroin the ultimate narcotic in each case. The youths are attractive, articulate, of mixed racial and social backgrounds, and project an air of honesty and painfully earned expertise. They are filmed in various institutional settings -- jails, halfway houses -- but the camera focuses on their faces. Their statements are grouped by general subject: how they got started on drugs, what it feels like to kick the habit, what their families went through as a result of their addiction.

LSD. (Produced by the Bureau of Medicine & Surgery, United States Navy. Loan Source: Audiovisual Branch, United States Navy, Pentagon, Washington, D.C. Intended Audience: Servicemen. 1967, Color, 28 minutes.)

Lt. Cdr. Walt Miner of the United States Navy Medical Corps delivers a lecture on the history, properties and effects of LSD. Intended audience: the man who is considering taking the drug, and the man who must decide whether he wants to go to sea with a crewmate who has. Emphasis is placed on the drug's phenomenal potency; its ability to create a mental state resembling insanity in the user; the possibility of recurrent effects without further drug use; the risk of permanent psychosis, suicide, genetic damage; and, most important, the total unreliability in stressful military situations of a one-time LSD user. For the seaman, Dr. Miner says, "an alcoholic binge is infinitely less harmful than an LSD trip because the drunken sailor will dry out at sea, but the acid-user may, without warning, experience a recurrence triggered by common shipboard and aeronautical phenomena such as enclosed spaces and panels full of flashing colored lights." He concludes with the thought: "I want you to think about what I have just said very carefully."

LSD-25. (Sponsored by San Mateo (California) Union High School District. Produced by Professional Arts, Inc., P.O. Box 8484, Universal City, California 91608. Dr. David W. Parker, producer. Intended Audience: Senior High School & College Students, Adult & General. 1967, Color, 27 minutes.)

The chemical compound LSD-25 is given a voice, and tells viewers of its nature and effects. Scenes illustrating the narrative accompany. False information about the drug is rebutted, the facts of its unpredictability and unknown properties are emphasized. Potency, illegality, uncertain dosages when prepared by backstreet chemists, bum

trips, self-injury or suicide while under the influence, recurrence of effects, alterations in brain-wave tracings following use, possibility of associated cell changes and chromosomal damage -- these are some of the dangers cited. The strange thing, LSD concludes, is that a user's reaction depends, "not on my chemistry, but on his. I can give him a trip to his inner brain-scape. Of course, he may be terrified by what he sees there. But that's his problem, not mine."

LSD: A TRIP TO WHERE? (Produced by McGraw-Hill Films, Dept. DF, 330 West 42nd Street, New York, New York 10036 in cooperation with WABC-TV. Intended Audience: Senior High School & College Students. 1968, B&W, 25 minutes.)

The film opens with a series of interviews, including LSD's most publicized advocate, Dr. Timothy Leary. Dr Sydney Cohen, at the time psychiatrist on the staff of Bellevue Hospital, and others offer differing views. In the latter part of the film, various research studies are quoted, and the audience is cautioned that LSD's potential dangers far outweigh any possible benefits.

LSD: INSIGHT OR INSANITY? (A Med-Cine Production, written by Richard S. Scott, M.D., and Max Miller (Producer-director). Distributed by Bailey Films, 6509 DeLongpre Avenue, Hollywood, California 90028. Intended Audience: Junior & Senior High School Students, Adults & General. Narrated by Sal Mineo. 1968(Revised), Color, 28 minutes.)

The film opens with good-natured ribbing of teen-age faddism -- goldfish swallowing, telephone booth cramming, hippie clothing and hairstyles -- then moves to less socially desirable fads -- gang fights, automobile "chicken" contests -- to experimentation with drugs. Eight doctors and a pharmacologist involved in LSD research then explain and illustrate their findings. Consensus: LSD remains, largely, an unknown quantity, and its unsupervised use is extremely dangerous. The possibility that LSD exercises damaging genetic effects on humans is emphasized. Teratogenesis (production of deformed offspring), carcinogenesis (production of cancers) and mutagenesis (production of successive generational damage) are cited as some of the results of LSD experiments on animals. Visual material accompanies: deformed foetuses borne by guinea pigs dosed with LSD in pregnancy are shown, along with photos of chromosomal breaks and abnormalities associated with human LSD ingestion. The film closes with former USFDA Commissioner James L. Goddard warning that LSD experimentation is like playing Russian roulette. A game of Russian roulette is dramatized, and in the film's final sequence the gun fires.

LSD: LETTVIN VS. LEARY. (Produced by WGBH-TV, Boston, Massachusetts for the National Educational Television Network. Distributed by NET Film Service, Indiana University AudioVisual Center, Bloomington, Indiana. Intended Audience: General. 1967, B&W, 54 minutes.)

Former Harvard psychologist Timothy Leary, the chief prophet of the LSD Gospel, expounds the doctrine of his League for Spiritual Discovery to an audience at Massachusetts Institute of Technology. In rebuttal: MIT Professor Jerome Lettvin, M.D., and former mental hospital senior psychiatrist. Leary: "The proper aim of man is to tune in to the ancient cellular wisdom of his 2-billion-year-old body. We have been narcotized by print, by society, by conventional education. So we need an antidotal sacrament -- LSD. Sure there are risks: everything worth doing involves risk. But there is no substantive evidence that LSD causes damage. Marijuana should be legalized too. Turn on, tune in, drop out." Lettvin: "The problem is whether the navel really replaces television. Forbidding marijuana is nonsense, of course. But the psychedelic drugs are something else. They give no guarantee that judgment will be returned once it has been taken away. Users pay for their vision of the self by a loss of the noetic function -- the critical faculty that distinguishes man from all other creatures. The LSD experience resembles, frighteningly, the temporal lobe syndrome that characterizes axe-murderers and epileptics. A group of physicists who took psilocybin were unable to do theoretical work for six months afterwards. LSD insight is cheap--but it is bought dearly."

LSD: THE SPRING GROVE EXPERIMENT. (Produced by CBS News, John Sharnik producer/writer. Presented by McGraw-Hill Text-Films, 330 W. 42nd Street, New York, New York 10036. Intended Audience: Senior High School & College Students, Adults & Professionals. Narrated by: Charles Kuralt. 1966, B&W, 54 minutes.)

The film documents a program (at Baltimore's Spring Grove State Hospital where controlled experiments have been conducted using LSD as a therapeutic tool in psychiatric treatment) through two subjects -- a 48-year-old housewife who suffered an acute emotional breakdown, and a 33-year-old male alcoholic. Their preparation--intense psychometric testing and 15 hours of conventional psychotherapy--their LSD treatment--one 14-hour session in a supervised, carefully arranged setting--and subsequent return to useful life are depicted. Both, six months after LSD, were functioning healthily for the first time in many years. Although still experimental, the program suggests that LSD can be a boon to society as well as a bane. "We should not let the negative be emphasized so much that the positive aspects are swamped," urges Dr. Joel Elkes, chairman of the Johns Hopkins University Department of Psychiatry, in a final comment.

LSD TRIP--OR TRAP! (Produced by Sid Davis Productions, 2429 Ocean Boulevard, Santa Monica, California 90405. Intended Audience: Senior High School & College Students. B&W, 20 minutes.)

Two teen-age boys, Bob and Chuck, have many interests in common and enjoy each other's company. However, when another boy, Frank, tries to introduce them to LSD, they disagree. While Chuck lets himself be persuaded to join Frank's "acidheads," Bob decides to find out the truth about the notorious drug for himself. What he learns is disturbing to him and he realizes that he must warn his friend, who by now is firmly ensconced with Frank's crowd and already has taken several "trips." Bob puts his findings and feelings in a letter but on his way to mail it. Bob comes upon a grisly accident. Chuck has had a shattering recurrence of the LSD effects while driving, lost control of his car and rammed head-on into another car. Chuck is dead.

MARIJUANA. (Produced by Avanti Films, Los Angeles, California. Max Miller, writer/producer. Distributed by Bailey Films, 6509 DeLongpre Avenue, Hollywood, California 90028. Intended Audience: Junior & Senior High School & College Students & Adults. 1968, Color, 34 minutes.)

Pop-singer Sonny Bono conducts viewers through this contemporary examination of the pros and cons of marijuana use. The film opens with scenes of a teen-age pot party which is suddenly broken up by the police. As they are handcuffed and wrestled out the door, the participants scream justifications for the legalization and consumption of marijuana. The arguments are then isolated, each providing the lead-in for a discussion of one particular aspect of the marijuana controversy. Among reasons for not using marijuana cited by Sonny are included the risk of a bum trip resulting from a very high dosage; the possibility that teen-age immaturity "sets you up" for psychological dependency; the chance that marijuana use will lead to indulgence in stronger drugs; the danger that altered physical and mental states will affect performance in driving or other critical tasks; and the argument that pot is illegal -- and the laws governing individual behavior are justified by the need to provide for the common welfare. Sonny admits that alcohol and tobacco are both drugs which are legal but frequently abused, denies that this makes a case for legitimation of another. Although smoking is hazardous to health, he agrees, it does not cause impairment of judgment or dexterity. Would you like it, he poses, if the doctor who operated on you was high on marijuana? Moreover, experience with smoking and drinking indicates that not everyone can quit any time, he declares. Too many people would become drug dependent if marijuana were legalized. And, he notes, marijuana has been outlawed by the United Nations, the World Health Organization and most major countries of the world. Using a drug merely because others encourage it is a sign of weakness, he adds. The film ends with exhortations by a series of young people

who condemn the use of drugs, urge involvement in society's struggles, and express their admiration for people who come to grips with problems unaided. "It's your life," Sonny concludes. "It's up to you to decide."

MARIJUANA. (CBS Reports. Distributor: Carousel Films, Suite 1503, 1501 Broadway, New York 10036. Intended Audience: Law-enforcement Personnel & Adults. 1968, Color, 52 minutes.)

An unemotional, objective approach characterizes this report on current opinion about marijuana. Judges, lawyers, doctors, congressmen, and policemen express their views. A college-educated career girl in her mid-twenties smokes "pot" and says why. Ex-addicts from New York City's Phoenix House explain the dangers of graduating from marijuana to hard drugs, and Ithaca high school students say they think severe penalties are driving the problem underground rather than solving it.

MARIJUANA: THE GREAT ESCAPE. (Produced by Bailey-Film Associates, 11559 Santa Monica Boulevard, Los Angeles, California 90025. J. Gary Mitchell, producer. Intended Audience: Junior & Senior High School Students. 1969, Color, 20¼ minutes.)

George Willis' major interests are drag racing and a girl named Pat Allen. He is successful as a racer and his relationship with Pat is a happy one. George uses marijuana regularly and tries to persuade Pat to become a user. The experiences of George and Pat provide a data bank about marijuana that will lead students to a discussion of its effects and of the forces acting to encourage the use of drugs among young people.

MONKEY ON THE BACK. (Produced by the National Film Board of Canada, Grant McLean, producer. Distributed by McGraw-Hill Films, 330 W. 42nd Street, New York, New York 10036. Intended Audience: General. 1956, B&W, 27 minutes.)

A dramatized account of the life and drug-induced death of a Canadian heroin addict and is based on an actual case history. In 1945, Dick Smith is released from prison, having served a term for heroin possession. He has vowed to make a new life, but is unable to resist the temptation to return to the "needle." He loses his job, loses his wife and family, finds himself on a treadmill with prison stays the only respite. In spite of good intentions and growing self-knowledge, he cannot break his dependence on the drug. Eleven years later, on parole and only one day after declaring again his intention to stay clean and take a new job, he dies of an overdose.

NARCOTICS: A CHALLENGE TO YOUTH...OR...TO TEACHERS. (Sponsored and distributed by the Narcotic Educational Foundation of America, 5055 Sunset Blvd., Los Angeles, California 90027. Produced and directed by Gilbert Lasky, with financial assistance of the National Women's Relief Corps, Auxiliary to the Grand Army of the Republic, Inc. Intended Audience: Teachers, Junior & Senior High School Students & Adults. 1956, Color, 25 minutes.)

Narrator Lowell Thomas exhorts teachers to grapple with the drug problem and provides a quick survey of what the problem is. "Narcotics" are classified: opiates (heroin, morphine), marijuana, cocaine and the "dangerous drugs" (barbiturates, amphetamines). Drug displays are exhibited while medical uses, if any, and effects of abuse are summarized. The pattern of drug abuse among the young is then dramatized. It "usually begins in poorer neighborhoods, "where a boy with a problem -- sexual, economic, familial -- "self-pitying, emotionally immature, easily frustrated," turns to drugs. Often, the film says, he has been delinquent in the past. Gambling, truancy and theft are part of the pattern. Marijuana, which gives more kicks than alcohol, is a common starting point. "Usually" the boy then "looks for a bigger kick" -- heroin, "Goofballs, and bennies just serve as a stepping stone to heroin," it is learned. The protagonist of the screen drama becomes addicted, is arrested by police because his arms show needle marks, suffers withdrawal, returns from prison to his old haunts, where he will probably get hooked once again. He probably doesn't have much education, he has no skills, and he has bad friends, Thomas explains. However, "education, for some, could be immunization. Remember, " he says, "don't exaggerate. The facts are terrible enough. Your community counts on you."

NARCOTICS: THE DECISION. (A United Research & Training Production, distributed by Film Distributors International, 2223 South Olive Street, Los Angeles, California 90007. Intended Audience: Senior High School Students. 1961, Color, 30 minutes.)

The kind of human being one will be is determined by his brain -- the sum total of acquired knowledge and experience stored in this complex organ as it develops (in animation). The narrator adds that "much depends on what the individual has decided to put there for his own use." In the case of the central character in this cautionary film drama, what she puts there is a fog of alcohol, goofballs, pep pills, marijuana and heroin. She is suitably rewarded. The narrator announces (as the animation fades): "In the beginning God created man in His own image." A baby girl is shown with her mother, emerging from the hospital. "But this is the story of a junkie, a hype. It is the story of this girl's 18-year journey into Hell!" The journey begins when the heroine comes home one night to find her parents out. Her reaction is rather intense: she samples the liquor cabinet, then she goes to a party and blithely gulps an assortment of sedative and stimulant pills. "She has found a crutch to escape her difficulties.

She has made her decision," the narrator declares. From there the descent is dizzying. She learns to smoke marijuana, under instruction from a pusher. "It is inevitable that with the passage of time the user will drift into a group and become enmeshed in their silent society of fear," the film informs. The girl becomes addicted to marijuana, falls into the clutches of a heroin dealer who seduces her to that habit, eventually becomes a thief, and ends up a murderess. The narrator concludes by saying: "The girl whose own decision was escape from reality and responsibility becomes an entry on a police blotter. This is the end. Except she still has withdrawal sickness to look forward to."

NARCOTICS -- THE INSIDE STORY. (Produced by Charles Cahill & Associates, Inc., P.O. Box 3220, Hollywood, California 90028. Intended Audience: Junior & Senior High School Students. 1967, Color, 12 minutes.)

Young teen-agers having fun on the beach are used to illustrate the functions of the five senses and the central nervous system. The effects of drugs (classified as either stimulants or depressants) on the central nervous system -- the "Inside Story" -- are then examined. Drugs discussed, in the film's terminology, include narcotics, LSD, marijuana, tranquilizers, sedatives. The visual material is clinical: experimental animals, doctors, laboratory test-tubes, rather than sociological. There are no scenes of drug-taking or withdrawal. Viewers are warned of the dangers of drug abuse, exhorted not to impair their senses, urged to exercise their sixth sense -- common sense.

NARCOTICS: PIT OF DESPAIR. (Produced by Film Distributors International, 2223 South Olive Street, Los Angeles, California 90007. Mel Marshall, producer. Intended Audience: Senior High School Students. 1965, Color, 28 minutes.)

A dramatization of a clean-cut youth's downfall: from two Benzedrine tablets to heroin addiction and prison. John Scott, a college athlete who drives a sports car, has problems -- his grades are poor, he begins taking pills, he is a procrastinator. Instead of studying he goes to a party hosted by a bearded friend who has become a narcotics pusher. There John drinks too much beer, smokes cigarettes, dances with a beautiful fallen woman. She is a pusher and she urges him to try marijuana. "He struggles with his conscience, surrenders his dignity," says the narrator, "and lays his future on the line." Soon he is failing in his studies, is cut from the track team, and "psychologically dependent" on marijuana. Next, coaxed by pusher-friend, he tries heroin. He becomes addicted, experiences withdrawal agony, is permanently hooked and finally goes to prison. "There Is No End," the title informs as the film ends.

NARCOTICS -- WHY NOT. (Produced by Charles Cahill & Associates, Inc., P.O. Box 3220, Hollywood, California 90028. Technical Advisors: United States Public Health Service, California Bureau of Narcotics, California Rehabilitation Center, Los Angeles Sheriff's Department. Intended Audience: Junior High School Students -- Adult. 1966, Color, 15 minutes.)

Dramatizations of drug taking, arrest, etcetera are interlaced with reminiscences by sixteen male and female ex-addict residents of the California Rehabilitation Center at Corona. Emphasis is placed on the unpleasantness of the drugged state and the addict's life, with secondary weight given to the pains of arrest and imprisonment.

SEDUCTION OF THE INNOCENT. (Produced by Sid Davis Productions, 2429 Ocean Park Blvd., Santa Monica, California. Produced with cooperation of the Santa Monica Police Department and the Santa Monica Unified School District. Intended Audience: Junior & Senior High School Students. 1960, Color, 10 minutes.)

The film, a dramatization, with narrated sound track, depicts the progress of a 20-year-old protagonist from causal experimentation with pills (Seconal, Tuinal, bennies) to marijuana use to heroin addiction. As the denouement approaches, she has lost her looks and can no longer command a call-girl's fees. She takes to streetwalking. She is arrested and begins to experience withdrawal. The future holds little hope. Drug abuse, the narrator promises, "will lead to a life of hopelessness and degradation, until she escapes in death."

SPEEDSCENE: THE PROBLEM OF AMPHETAMINE ABUSE. (Produced by Bailey-Film Associates, 11559 Santa Monica Blvd., Los Angeles, California 90025. A Medi-cine Films Production. Intended Audience: Junior & Senior High School & College Students & Adults. 1968, Color, 17 minutes.)

The abuse of amphetamine drugs is documented in this film. The dangers are considerable. Certainly, the most destructive form of amphetamine abuse is the repeated intravenous injection. The frequent consequences of unsterile drugs injected into the blood stream with unsterile equipment include local infections and abscesses at the injection site, hepatitis, and general malnutrition. The use of amphetamines becomes compulsive. Although physical addiction does not occur, there develops a psychological dependence upon the effects of the drug and a craving for the "highs" it gives. Besides the psychological factor of dependence, other extremes of the life style and social climate of confirmed amphetamine users pose serious personal threats. As Dr. David E. Smith points out in the film, the physical and psychiatric damage of amphetamine abuse far exceeds those of LSD and marijuana together.

THE ADDICTED: CRIMINAL OR PATIENT? (Produced by CBS News. Distributed by Association Films, Inc., 600 Grand Avenue, Ridgefield, New Jersey 07657. Intended Audience: General. 1958, B&W, 28 minutes.)

A segment of a two-part series about drug addiction originally shown on the CBS Television series, "The Twentieth Century," with Walter Cronkite narrator. The film examines the accuracy of the colloquial phrase "dope fiend," and coming to the conclusion that the heroin addict is, almost by definition, a passive personality. His goal is oblivion: escape from his problems by "going on the nod." While under the drug's influence he will almost certainly be incapable of violent crime -- assult and/or murder -- and will not even rival the alcoholic as a menace behind the steering wheel. Ex-addicts are interviewed to bolster these contentions. On the other hand, addiction forces the user to spend great sums of money to maintain his illegal habit, with the result that almost one-half of all reported crimes in major cities are associated with drug abuse. One interviewee supported a $30-a-day habit for ten years by shoplifting and with an addict partner stole $200 worth of merchandise daily to net the $60 needed by both for drugs. The ten-year total crime bill for the pair was in excess of $700,000! Addiction is a symptom of a disease, the film declares. But in order to seek a cure, the addict who turns himself in must usually go to prison. There he will kick the habit "cold turkey" -- without medication. Treatment facilities and social welfare services are almost invariably closed to the addict or ex-addict. Punitive measures have clearly failed to stem the tide, concludes New York City Commissioner of Corrections Anna Kross: "We haven't even made a beginning. We must create a climate in which addiction will be considered a medical-social and health problem -- not a crime problem."

THE AGENTS OF DRUG ABUSE. (Produced by Penelope Films, Inc., 1440 Clay Street, San Francisco, California 94109. Intended Audience: Teachers & Health Educators. Color, 38 minutes.)

A review of all drugs of abuse, discussing levels of abuse, effects, legal consequences and penalties pertaining to the various agents of drug abuse.

THE CIRCLE. (Produced by the National Film Board of Canada in cooperation with McGraw-Hill Films, 330 West 42nd Street, New York, New York 10036. Intended Audience: Senior High School & College Students. B&W, 57 minutes.)

This stark film portrays the experiences of a drug addict who voluntarily enters a treatment center to kick his habit.

THE DANGEROUS DRUGS. (Sponsored by the Narcotic Educational Foundation of America, 5055 Sunset Blvd., Los Angeles, California 90027. Produced by Ronald Munns. Intended Audience: Senior High School Students -- Adults. 1966, Color, 22 minutes.)

Ronald Reagan, as a public service, narrates this examination of the problem of barbiturate and amphetamine abuse. Dramatic silent vignettes illustrate common forms of abuse: youths at a party poping pills for a thrill; a distraught middle-aged woman, seeking solace and sleep, ends by dosing herself fatally; a truck driver trying to stay awake suffers hallucinations and crashes; and a young girl tells of her unhappy experiences as a chronic pill abuser. Withdrawal from barbiturate addiction -- more painful and dangerous, the film notes, than withdrawal from opiate addiction -- is depicted. "The solution," the film concludes, "lies in widespread education. Then and only then will legislation be developed to cope with this menace."

THE HIPPIE TEMPTATION. (Produced by McGraw-Hill Text Films, 330 West 42nd Street, New York, New York 10036. Intended Audience: General. 1967, Color, 57 minutes.)

The film alternates between on-scene visits to Hippie haunts and observations in various medical and psychiatric facilities. It opens with a view of street scenes at "Hippie Hill," Golden Gate Park, and the Haight-Ashbury area of San Francisco. Commentator Harry Reasoner conducts the camera tour and narrates the production. The film explains that apart from the manner of living and forms of recreation, the Hippie philosophy of withdrawal rather than participation is based, to a great degree, on the "mind-expanding" potential of LSD. The effects of this drug are described as terrifying and resulting in irreversible psychological and chromosomal damage. The narrator summarizes from a standpoint of social values that this is a philosophy with style but no content, that the proffered remedy for social ills is not action but withdrawal, and that it is, after all, an attempt to substitute hallucination for a philosophy of life.

THE LOSERS. (Produced by the Columbia Broadcasting System, Jack Landau producer/writer/director. Distributed by Carousel Films, Inc. c/o Association Films, 600 Grade Avenue, Ridgefield, New Jersey. Free Loan Source: State of California Department of Public Health, Bureau of Health Education Film Library. Intended Audience: General. 1960, B&W, 31 minutes.)

Produced by CBS News, this film employs the documentary style -- interviews, a narrator shot in various location backgrounds, illustrative footage showing seedy neighborhoods, an arrest, a jail, a hospital, a morgue, a high school classroom in which a rat is enclosed in a glue-coated fish tank -- to blanket the subject of drug addiction. "Police estimate that 35% of all drug experimenters will get hooked," the narrator declares. An official of Daytop Village

rehabilitation center offers the opinion that "we believe drug addiction is an acting-out of infantile behavior." The film opens and closes with scenes of the New York City morgue, where a body is being filed away, the fatal result of acute intravenous narcotism. The moral is that drug experimenters are flirting with death.

THE MIND BENDERS -- LSD AND THE HALLUCINOGENS. (Sponsored by the United States Food & Drug Administration. Produced by Vision Associates, Lee R. Bobker, writer/director. Free Loan Source: PHS Audio-Visual Facility, Chamblee, Georgia 30005. Intended Audience: Senior High School & College Students, Teachers & Adults. 1968, Color, 26 minutes.)

Young LSD users tell why they took the drug, what it did for them, and how it has affected their lives. On the other side of the fence, UCLA psychiatrists Duke D. Fisher and J. Thomas Ungerleider, and NYU Medical School Professor Marvin Stern, warn of the hazards: bum trips, recurrent flashes, impulse to drop out of conventional society. Since the beginning of time, the narrator notes, man has had a desire to alter his perception. Some of the powerful chemical substances by which he is able to accomplish this are psilocybin, mescaline, DMT and LSD -- the hallucinogens. Since the latter is the most prevalent, and currently in greatest demand, the film concentrates on its characteristics. The viewer learns what is known: LSD is extremely potent, but its perception-changing mechanism remains largely a mystery. It has caused abnormal and premature births in one study utilizing five guinea pigs; it has been associated with chromosomal breaks in human users; it may cause psychological dependency in some users. But LSD may also be a vehicle for good. An LSD-treatment program for alcoholics in Kansas City is examined. Other experimental therapeutic uses for LSD are mentioned: treatment of the mentally ill, psychological adjustment to death for terminal cancer patients. "The evidence is inconclusive," the narrator admits. "We just don't know enough." But the film ends with this caveat for casual experimenters: The facts suggest caution, and a careful counting of the cost."

THE PEOPLE NEXT DOOR. (Produced by CBS. Distributed by Bailey Films, 6509 De Longpre Avenue, Hollywood, California 90028. Intended Audience: Junior & Senior High School & College Students & Adults. 1969, B&W, 81 minutes.)

In this CBS Playhouse drama, two middle-class couples discover that drugs have entered the lives of their children. One of the fathers, Mason, is characterized as a hearty backslapper with fuzzy standards who despite his apparent decisiveness is a man who tries to avoid responsibility. Mason can't understand his son's long hair and hippie attire. The son bears no hatred for his father but considers him without integrity or real purpose. The gap in standards widens when screams from upstairs reveal the daughter in the middle of an LSD "bad trip." Thinking his son has supplied the drug, the father throws him

out. Temporarily calming the daughter and after an argument about "What will the neighbors think?" the Masons ask their next door neighbors for help. This second couple, the Hoffmans, consists of the father, his hyperactive wife, and their son, an apparent model of young respectability. Hoffman advises the Masons to seek understanding with their daughter. They try when the daughter awakens, but the basic disagreement in values only results in the daughter running away to New York's East Village. She is eventually found in a shabby flat with a sullen young man. The Masons and their daughter under go group therapy, apparently helpful until the daughter "freaks out" again, this time so badly she must be committed to a mental institution.

THE RIDDLE. (Produced by Public Affairs, Office of Economic Opportunity, 1200 19th Street, N.W., Washington, D.C. 20506. Intended Audience: Junior & Senior High School Students. Color, 28 minutes.)

The camera follows actual glue-sniffers, cough medicine drinkers and heroin addicts into the alleys, tenements and physicians' offices where their candid comments and bewildered responses clearly show the hopelessness of their lives. By contrast, an account of a youth who resists the drug abuse crowd to land a job strikes a hopeful note.

SCENT OF DANGER. (Produced by Gordon Newsfilms, San Francisco, California 94103. Sponsored by the Hobby Industry Association. Free Loan Source: State of California Department of Public Health, Bureau of Health Education Film Library. Intended Audience: Adults, Professionals & Civic Groups. 1962, Color, 13 minutes.)

This film informs the viewer of a small minority of boys with weak personalities and needing a crutch to build up their confidence, sniff glue. Moreover, they sniff lighter fluid, wood dough, cosmetics, paint thinner, kerosene, hair spray, medicated inhalers -- in short, almost anything containing aromatic hydrocarbons. A teen-ager who could not break the sniffing habit is interviewed. The efforts of the city of Anaheim, California, to curb the sniffing wave are reviewed. "The best answer is legislation at the local level," the narrator declares. Meanwhile, it is learned that the hobby industry has launched a nationwide campaign of research to reduce glue's adverse effects when sniffed, to urge shopkeepers to keep their glue watched and locked away, and to promote local action.

THE SEEKERS. (Sponsored by the New York State Council on Drug Addiction. Produced by Myron Solin. Distribution by the State of New York Narcotic Addiction Control Commission, Albany, New York 12203. Intended Audience: Senior High School Students & Young Adults. 1967, Color, 30 minutes.)

Young ex-drug-users and ex-addicts, members of an organization known as Encounter, discuss the unpleasantness of their lives when they were taking "dope." They are filmed chatting among themselves, before groups of straight high school students, and with hippies. They condemn drugs vociferously and across the board. The hippie life is dismissed as a "cop-out" from responsibility to act against adverse social conditions. There is a short sequence in which a young girl who used LSD "has her chromosomes checked." The types of genetic damage LSD may cause is explained. Otherwise the approach is sociological, non-technical. "The question," one of them warns his young audience at the film's conclusion, "is how stupid are you going to be? You can be a little bit stupid, you can be very stupid, or you can be the least stupid possible."

THE TERRIBLE TRUTH. (Produced by Sid Davis Productions, 1418 North Highland Avenue, Hollywood, California 90028. Free Loan Source: State of California Department of Public Health, Bureau of Health Education Film Library. Intended Audience: Senior High School Students. 1951, B&W, 10 minutes.)

An elderly Juvenile Court Judge frowns at newspaper headlines screaming, "TEEN-AGERS HELD ON DOPE CHARGES." "Would you believe," he asks, "that here in America, in the second half of the 20th Century, we would be reading stories such as these?" To illustrate this terrible truth he talks with a middle-class teen-age girl who has just come out of jail where she kicked the heroin habit. Her downward spiral is dramatized--from a couple of puffs of marijuana to a syringe full of heroin to marriage with a pusher to addiction to prostitution to theft, etcetera. The judge concludes with a plea to young American boys and girls to show the world that they're too strong, that their moral fiber is too firm, to succumb to the siren appeal of drugs.

TOMORROW MAY BE DYING. (Produced by the Cinema Department Graduate Workshop, University of Southern California, University Park, Los Angeles, California 90007. Intended Audience: Senior High School & College Students. 1960, B&W, 23 minutes.)

A dramatization, the title of the film comes from a line from the verse beginning: "Gather ye rosebuds while ye may. . .." It is quoted by one of the characters to justify drug experimentation, reckless driving, rolling drunks, and other anti-social pastimes he finds amusing. The central character is Jeanne, a girl who acquires a heroin habit and a pregnancy from her pusher boyfriend. He abandons her in the seventh month when she can no longer support him by street-walking. With the

expectant birth approaching, Jeanne insists an arrangement be made for an illicit home delivery because she can't risk a hospital birth for fear of arrest. But the doctor warns that the baby must receive hospital care because it is hooked, too, and may die of drug withdrawal. Jeanne wrestles with her conscience and finally submits. She is led off by police to kick her habit -- that agony providing the opening scene of the film.

TRIP TO WHERE. (Produced by DuArt Films Laboratories, 245 West 55th Street, New York, New York 10019. Free Loan Source: Naval District, Washington, D.C., Building 200, Navy Yard Annex, United States Navy, Washington, D.C. 20390. Intended Audience: Senior High School & College Students, Teachers & Health Educators. Color, 49 minutes.)

Film presents dangers of use and abuse of three basic groups of drugs: namely, amphetamines, barbiturates and hallucinogens -- including marijuana and emphasizing LSD. Points out psychological and physical effects, expecially in relation to potentially dangerous effects on individual performance in critical operations.

WAY OUT. (Produced by Valley Forge Films, Inc., Chester Springs, Pennsylvania 19425. Intended Audience: General. Color, 105 minutes.)

A theatrical trip into the world of drug addiction. The principal roles are played by eight real life addicts who have kicked the heroin habit against impossible odds.

AUDIO-VISUAL PROGRAMS.

DCA EDUCATIONAL PRODUCTS. Two sets of colored transparencies developed in consultation with the United States Food & Drug Administration by DCA Educational Products, Inc., 4865 Stenton Avenue, Philadelphia, Pennsylvania 19144. The first set consists of 22 units on, "How Safe Are Our Drugs," at $54.75 and the second series, 20 units on, "The Use and Misuse of Drugs," at $59.75. Complete transparency set, $114.50.

INTERNATIONAL EDUCATION & TRAINING INC. This multi-media program provides students with various types of drug abuse and the effects of drugs on the body. Materials stimulate discussion and help students reach positive conclusions concerning drugs and drug abuse. Complete program (62 overhead transparencies, six 15 minute audio reel-to-reel or cassette tapes, 3 books, $264.50) from International Education & Training, Inc., 1776 New Highway, Farmingdale, New York, New York 11735.

LOCKHEED MISSILES & SPACE COMPANY. A 15-hour course of instruction aimed at junior and senior high school students entitled, "Drug Decision," consisting of a three-hour movie-animation segment produced by Warner Brothers; 300-page student response and decision manual; five-hour teacher preparation and data file. Price on request from Lockheed Information Systems, Box 504, Sunnyvale, California 94088.

POPULAR SCIENCE PUBLISHING COMPANY. "Drugs and Your Body," a set of 20 transparencies, $119 with teaching guide. These transparencies deal with the scope and magnitude of this serious problem. For additional information contact Popular Science Publishing Company, New York, New York 10017.

RAYTHEON LEARNING SYSTEMS COMPANY. Set of ten film strips on drugs, each with record, teachers guide, and pad of 50 score sheets for student participation. Series covers: "Barbiturates and Amphetamines," "Marijuana," "LSD," "Narcotics," and "Teen-agers and Drugs." Complete drug set $250 from Raytheon Learning Systems Company, 475 South Dean Street, Englewood, New Jersey 07631.

SCHOOL HEALTH EDUCATION STUDY (3M COMPANY). A Unified and comprehensive health education program developed by the School Health Education Study, 1507 M. Street, N.W., Room 800, Washington, D.C. 20005 and marketed by 3M Company, Box 3100, 3M Center, St. Paul, Minnesota 55101. Set of four books in four grade levels from kindergarten through 12th grades, plus teacher-student resource on, "Use of Substances that Modify Mood and Behavior," set $10.00 from 3M Education Press, Box 3344, St. Paul, Minnesota 55101. Four sets of color transparencies, each containing 20 visuals for Level 1 (Kindergarten through 3rd grades); four sets for Level 2 (4th

through 6th grades); five sets for Level 3 (7th through 9th grades), and six sets for Level 4 (10th through 12th grades), $33.00/set.

TEXAS ALCOHOL NARCOTICS EDUCATION, INC. Filmstrip with 33 1/3 rpm record and booklet on each of five subjects: "Alcohol: Fun or Folly;" "Smoking. . .or Health;" "Glue Sniffing: Big Trouble in a Tube;" "LSD: Trip or Trap;" and "Why Not Marijuana." Authored by Lindsay R. Curtis, M.D., for the Texas Alcohol Narcotics Education, Inc., 2814 Oak Lawn Avenue, Dallas, Texas 75219, $10.95/set.

APPENDIX D

A GLOSSARY OF TERMS RELATING TO DRUG ABUSE

A GLOSSARY OF TERMS RELATING TO DRUG ABUSE[14]

ACID -- LSD
ACID-HEAD -- An abuser of LSD
ARTILLERY -- Equipment for injecting drugs

BACKTRACK -- To withdraw the plunger of a syringe before injecting drugs to make sure needle is in proper position
BAD TRIP -- Bad experience with LSD or STP
BAG -- A container of drugs
BAGMAN -- A drug supplier
BANG -- To inject drugs
BARBA -- Barbiturates
BEAN -- Capsule
BENNIES -- Benzedrine (a commercial brand name for amphetamine sulfate tablets)
BERNICE -- Cocaine
BIG JOHN -- The police
BINDLE -- A small quantity or packet of narcotics
BIRD'S EYE -- Very small amount of narcotic
BIZ -- Equipment for injecting drugs
BLANKS -- Poor quality narcotics
BLASTED -- Under the influence of drugs
BLAST PARTY -- Group of Marijuana smokers smoking together
BLOW A STICK -- To smoke a marijuana cigarette
BLUE ANGELS -- Amytal (a commercial brand name for amobarbital capsules)
BLUE VELVET -- Paregoric and an antihistamine
BOMBIDO -- Injectable amphetamine
BOXED -- In jail
BOY -- Heroin
BREAD -- Money
BULL -- A Federal narcotic agent, a police officer
BUMMER -- A bad experience with psychedelics, such as LSD or psilocybin
BURNED -- To receive phony or badly diluted drugs
BUSTED -- Arrested
BUZZ -- Try to buy drugs

C -- Cocaine
CABALLO -- Heroin
CANDY -- Barbiturates
CAP -- A container of drugs (usually a capsule)
CARTWHEELS -- Amphetamine sulfate tablets
CHAMP -- Drug abuser who won't reveal his supplier--even under pressure
CHARGED UP -- Under the influence of drugs

CHIEF -- LSD
CHIPPING -- Taking small amounts of drugs on an irregular basis
CHIPPY -- An abuser taking small, irregular amounts
CLEAR-UP -- To withdraw from drugs
COASTING -- Under the influence of drugs
COKE -- Cocaine
COKED UP -- Under influence of cocaine
COKIE -- A cocaine addict
COLD TURKEY -- Sudden drug withdrawal without medication
COMING DOWN -- Recovering from a trip on drugs
CONNECT -- To purchase drugs
CONNECTION -- A drug supplier
COOK UP A PILL -- To prepare opium for smoking
COOKER -- Spoon or bottle cap used to prepare heroin
CO-PILOTS -- Amphetamine tablets
COP -- To purchase drugs
COP-OUT -- To alibi and/or confess
CORINE -- Cocaine
COTICS -- Narcotics
COTTON-HEAD -- Desperate user who recooks from previous supplies to eke out one more supply for injection
CRYSTALS -- Methamphetamine
CUBE-HEAD -- Frequent user of LSD
CUT -- To adulterate a narcotic by adding milksugar

D.D. -- A fatal dose
DABBLE -- To take small amounts of drugs on an irregular basis
DEALER -- A drug supplier
DECK -- A small packet of narcotics
DEXIES -- Dexedrine (a commercial brand name for dextro-amphetamine sulfate tablets)
DIME BAG -- A ten-dollar purchase of narcotics
DOLLIES -- Dolophine (a commercial brand name for methadone hydrochloride tablets
DOMINO -- To purchase drugs
DOO JEE -- Heroin
DOPE -- Any narcotic
DOPER -- Person who uses drugs regularly
DOUBLE TROUBLE -- Tuinal (a commercial brand name for amobarbital sodium and secobarbital sodium capsules)
DREAMERS -- Heroin
DOWNERS -- Sedatives, alcohol, tranquilizers, and narcotics
DROPPED -- Arrested
DUMMY -- Purchase which did not contain narcotics
DUST -- Cocaine
DYNAMITE -- Highly potent narcotic

EIGHTH -- Eighth of an ounce
ENDS -- Money

FACTORY -- Equipment for injecting drugs
FIX -- An injection of narcotics
FLAKE -- Cocaine
FLEA POWDER -- Poor quality narcotics
FLOATING -- Under the influence of drugs
FLY -- Take narcotics
FOOTBALLS -- Oval-shaped amphetamine sulfate tablets
FREAK OUT -- Bad or psychotic reaction to drug
FRESH & SWEET -- Out of jail
FUZZ -- The police

GAGE -- Marijuana
GEE-HEAD -- Paregoric abuser
GEETIS -- Money
GEEZER -- A narcotic injection
GIMMICKS -- The equipment for injecting drugs
GLUEY -- Young glue sniffer
GOLD DUST -- Cocaine
GOODS -- Narcotics
GOOFBALLS -- Barbiturates
GOW-HEAD -- An opium addict
GRASS -- Marijuana
GREENIES -- Green, heart-shaped tablets of dextro-amphetamine sulfate & amobarbital
GRIEFO -- Marijuana
GUN -- A hypodermic needle

H -- Heroin
HAND-TO-HAND -- Person-to-person delivery
HANG-UP -- A personal problem
HAPPY DUST -- Cocaine
HARD STUFF -- Opiates such as morphine and heroin
HARRY -- Heroin
HASH -- Hashish, the resin of Cannabis
HAWK -- LSD
HAY -- Marijuana
HEAD -- User of drugs, usually LSD
HEARTS -- Benzedrine or Dexedrine (a commercial brand name for amphetamine sulfate and dextroamphetamine sulfate tablets)
HEAT -- The police
HEELED -- Well-supplied with money and/or drugs
HEMP -- Marijuana
HIGH -- Under the influence of drugs
HIT -- To purchase drugs, an arrest
HOCUS -- A narcotic solution ready for injection
HOLDING -- Possessing narcotics

HOG -- Phencyclidine-hydrochloride
HOOKED -- Addicted
HOP-HEAD -- Narcotic addict
HOPPED UP -- Under the influence of drugs
HORN -- Sniff narcotics
HORSE -- Heroin
HOT -- Wanted by police
HOT SHOT -- A fatal dosage
HUSTLE -- Activities involved in obtaining money to buy heroin
HYPE -- Narcotic addict

ICE CREAM HABIT -- A small, irregular drug habit
INDIAN HAY -- Marijuana

JAG -- Under influence of amphetamine sulfate
JIVE -- Marijuana
JOB -- To inject drugs
JOINT -- A marijuana cigarette
JOLLY BEANS -- Pep pills
JONES -- The habit, an addict
JOY-POP -- To inject small amounts of drugs irregularly, usually a skin injection
JOY POWDER -- Heroin
JUNK -- Narcotics
JUNKIE -- A narcotic addict
JUVIES -- Juvenile officers

KICK -- To abandon a drug habit
KIEF -- Arabic for marijuana in dried resin form

KILO -- Large amount of narcotics
KIT -- Material for injections

LAYOUT -- The equipment for injecting drugs
LIPTON TEA -- Poor quality narcotics
LIT UP -- Under the influence of drugs
LOCOWEED -- Marijuana

M -- Morphine
MACHINERY -- Equipment for injecting drugs
MAINLINE -- To inject drugs directly into a vein
MAINTAINING -- Keeping at a certain level of drug effect
MAKE A BUY -- To purchase drugs
MAKE A MEET -- To purchase drugs
MAN -- The police
MANICURE -- Clean and prepare marijuana for rolling into cigarettes
MARY JANE -- Marijuana
MEMBER -- Negro or some other than white person

MESC -- Mescaline, the alkaloid of peyote, which produces effects similar to those of LSD
METH -- Methamphetamine, usually injected for rapid result, also referred to as Methedrine & Desoxyn
METH-HEAD -- Habitual user of methamphetamine
MEZZ -- Marijuana
MICKEY FINN -- Chloral hydrate
MIKES -- Micrograms (millionths of a gram)
MISS EMMA -- Morphine
MOJO -- Narcotics
MONKEY -- A drug habit where physical dependence is present
MOR A GRIFA -- Marijuana
MUTAH -- Marijuana

NARCO -- Narcotics officer
NEEDLE -- Hypodermic syringe
NICKEL BAG -- A five-dollar purchase of narcotics
NIMBY -- Nembutal (a commercial brand name for pentobarbital capsules)

O.D. -- Overdose or fatal amount of narcotics
OFF -- Withdrawn from drugs
ON A TRIP -- Under the influence of LSD or other hallucinogens
ON THE NOD -- Under the influence of drugs
ON THE STREET -- Out of jail
ORANGES -- Dexedrine (a commercial brand name for dextroamphetamine sulfate tablets
OUTFIT -- Eye dropper, cooker (spoon or bottle cap) used to prepare fix

PACK -- Heroin
PAD -- Drug user's home
PAPER -- A prescription or packet of narcotics
PEACHES -- Benzedrine (a commercial brand name for amphetamine sulfate tablets
PEANUTS -- Barbiturates
P.G. OR P.O. -- Paregoric
PIECE -- A container of drugs, usually one ounce
PILL-HEAD -- Heavy user of pills, barbiturates, or amphetamines
PINKS -- Seconal (a commercial brand name for secobarbital capsules)
PLANT -- A cache of narcotics
POP -- To inject drugs
POT -- Marijuana
POT-HEAD -- Heavy marijuana user
PURE -- Pure narcotics of very good grade
PURPLE HEARTS -- A combination of Dexedrine & Amytal called Dexamyl

PUSHER -- A person who peddles drugs

QUILL -- a folded matchbox cover from which narcotics are sniffed through the nose

RAINBOWS -- Tuinal (a commercial brand name for amobarbital sodium & secobarbital sodium capsules)
RAP -- Discuss at length
READER -- A prescription
RED DEVILS -- Seconal (a commercial brand name for secobarbital capsules)
REEFER -- A marijuana cigarette
RE-ENTRY -- Return from a trip
ROACH -- The butt of a marijuana cigarette
ROPE -- Marijuana
ROSES -- Benzedrine (a commercial brand name for amphetamine sulfate tablets)
RUMBLE -- Police in the neighborhood, a shake-down or search
RUN -- An amphetamine binge

SAM -- Federal narcotic agents
SATCH COTTON -- Cotton used to strain narcotics before injection
SCAT -- Heroin
SCHMECK -- Heroin
SCORE -- To purchase drugs
SCRIPT -- Doctor's prescription
SEGGY -- Seconal (a commercial brand name for secobarbital capsules)
SET-UP -- An arrangement to have someone caught dealing in illegal drugs
SHOOTING GALLERY -- A place where narcotic addicts inject drugs
SHOOT-UP -- To inject drugs
SHOT -- Injection
SILK -- A white person
SITTER -- LSD veteran who guides new user during trips; also called travel agent
SKIN-POPPING -- Injecting drugs under the skin
SIXTEENTH -- Sixteenth of an ounce
SLAMMED -- In jail
SLEIGH RIDE -- Cocaine
SMACK -- Heroin
SNIFF -- To inhal narcotics (usually heroin or cocaine) through the nose
SNORTING -- Same as sniffing
SNOW -- Cocaine
SPEED -- Methamphetamine, usually injected for rapid result

SPEED-BALL -- An injection which combines a stimulant and depressant -- often cocaine mixed with morphine or heroin
SPEED-FREAK -- Someone who habitually uses speed
SPIKE -- The needle used for injecting drugs
SPOON -- Sixteenth of an ounce of heroin
SQUARE -- A non-addict
STASH -- A cache of narcotics
STICK -- A marijuana cigarette
STOLLIE -- Informer
STP -- A highly potent hallucinogen
STRUNG OUT -- Addicted
STUFF -- Narcotics
SUGAR -- Powdered narcotics
SUPPLIER -- Drug source

TAKE A BAND -- Take drugs
TAKE-OFF -- Take drugs
TASTE -- Small quantity of narcotics usually given as sample or as reward
TEA -- Marijuana
TEA PARTY -- Marijuana party
TECATA -- Heroin
TEXAS TEA -- Marijuana
THOROUGHBRED -- A high-type hustler who sells pure narcotics
TOOIES -- Tuinal (a commercial brand name for amobarbital sodium and secobarbital sodium capsules)
TOSS -- Search
TOXY -- Smallest container of prepared opium
TRACKS -- Scars along veins after many injections
TRIP/TRIPPING -- Being "high" on hallucinogens, particulary LSD
TRUCK DRIVERS -- Amphetamine
TUNED IN -- Sympathetic to LSD use, or using it
TURKEY -- A capsule purported to be narcotic but filled with a non-narcotic substance
TURNED OFF -- Withdrawn from drugs
TURNED ON -- Under the influence of drugs

UNCLE -- Federal narcotic agent
UPPERS -- Stimulants, cocaine, and psychedelics

WAKE-UPS -- Amphetamine
WASHED UP -- Withdrawn from drugs
WASTED -- Under the influence of drugs
WEED -- Marijuana
WEED-HEAD -- Marijuana user
WEEKEND HABIT -- A small, irregular drug habit
WHISKERS -- Federal narcotic agents
WHITES -- Amphetamine sulfate tablets
WHITE STUFF -- Morphine

WORKS -- The equipment for injecting drugs

VIC -- One who has been given a hot shot, a victim

YELLOW-JACKETS -- Nembutal (a commercial brand name for pentobarbital capsules)
YEN HOOK -- Instrument used in opium smoking
YEN SHEE -- Opium ash
YEN SHEE SUEY -- Opium wine

APPENDIX E

DRAMATIC PRODUCTION: THE UNDERGROUND BIRD

THE UNDERGROUND BIRD[15]

SUBJECT: Drug Abuse

AUDIENCE: Bright young college students, sure they know more than their parents' generation about the pros and cons of "turning on," and eager for experience -- all experience.

WEAPON: Satire -- Half-hour drama

THE PLAY: A take-off on the drug scene that uses comedy to cut into the hidden motives of the addict -- and to reveal the infantilism and life denial that lie at the roots of drug abuse. THE UNDERGROUND BIRD:

Provides a pleasurable theatrical experience

Presents a variety of viewpoints about drug addiction, dependence and abuse

Suggests arguments pro and con for each point of view

Gives young people an opportunity for reflection, expression and clarification of their own thinking and goals with respect to the use of drugs

Carries the warning, "Beware, for there is that in all of us which, given its first heady taste of 'escape,' could catapult us down the tunnel of drug experimentation to the dead end of addiction"

Generates lively discussion (in an eastern university community, where the performance attracted an over-flow audience of students, it was reported that "the sparks were really flying" and the reaction of the audience was "tremendous")

Stimulates community concern about a problem that is real -- and threatening -- and growing -- but is not insoluble

May serve as an effective first step in developing a community action program to combat drug abuse.

THE UNDERGROUND BIRD can be performed by a college or community dramatic group. It can be staged in a large auditorium, at a luncheon meeting in a hotel ballroom, or in a classroom. No special props are needed. To get your "look-see" copy of this play, with discussion guide for leaders, send $2 with your request to: American Social Health Association, 1740 Broadway, New York, New York 10019.

APPENDIX F

COMPILATION OF FEDERAL LAWS REGARDING NARCOTICS AND DRUGS

COMPILATION OF FEDERAL LAWS REGARDING NARCOTICS AND DRUGS[16]

HARRISON NARCOTIC ACT. Termed the first effective narcotics control measure, this 1914 law initiated a policy which is still the basis of present drug control programs. Enacted as a revenue measure, the Treasury Department is designated as the enforcement agency.

As a revenue measure, the Harrison Act imposes a tax of one cent per ounce on narcotic drugs produced or imported in the United States and sold or removed from consumption or sale. The tax is imposed upon the following narcotic drugs: opium, isonipecaine, coca leaves and opiates; compounds, manufactures, salts, derivatives, or preparations of the foregoing; and substances chemically identical to the foregoing.

Payment of the tax must be evidenced by stamps affixed to the package or container. No person may purchase, sell, or distribute narcotic drugs unless he does so from a stamped package. Possession of narcotics in unstamped containers is "prima facie evidence of a violation."

The Act allows the Secretary of the Treasury to determine whether a pharmaceutical preparation containing a narcotic drug combined with other ingredients should warrant application of the law. Except for the dispensing of narcotic drugs to a patient by a practitioner, "in the course of his professional practice only" and the sale, dispensing, or distribution of narcotic drugs by a dealer to a consumer in pursuance of a practitioner's prescription, sale or transfer of narcotic drugs is unlawful except in pursuance of a written order or a recipient on an official form supplied by the Treasury Department.

Persons in the vocation involving the handling of narcotic drugs must register annually with the Treasury Department and pay an occupational tax graduated from one dollar to 24 dollars per year. They are also required to keep records, make them available to law officers, and file returns as required by the Secretary of the Treasury.

Traffic in narcotic drugs without registration is a separate offense, independent of failure to register. Thus, the transportation of narcotic drugs in interstate commerce by persons not registered is prohibited except for employees and agents of registrants within the scope of their employment.

JONES-MILLER ACT. Another major step in narcotics control by the federal government came with the passage of the Narcotic Drugs Import and Export Act of 1922, often referred to as the Jones-Miller Act. Its provisions appear in Title 21 of the United States Code. This act extended the prohibition against opium imports (set in 1909) to other narcotics including morphine, coca leaves, and their derivatives. Title 21 limits the amount of narcotics that may be lawfully

imported to such amounts as the Commissioner of Narcotics finds necessary for medical and legitimate uses.

The penalty for unlawfully importing or receiving, or facilitating transportation, or sale under the Jones-Miller Act is imprisonment for not less than five nor more than 20 years and a maximum fine of $20,000. Subsequent offences are punishable by a minimum sentence of ten years and a maximum sentence of 40 years, plus a $20,000 fine. A similar penalty was provided for smuggling marijuana.

*MARIJUANA TAX ACT. This Act requires registration and payment of a graduated occupational tax by all persons who import, manufacture, sell or otherwise distribute marijuana and was passed in 1937. Like the occupational tax applicable to narcotics, the fee ranges from one dollar to 24 dollars per year. Transfer of marijuana is limited to that made on the authority of official order forms. A tax is levied on all transfers of marijuana at the rate of one dollar per ounce or fraction thereof if the transfer is made to a taxpayer registered under the Act, or at the rate of $100 per ounce if the transfer is made to a person not a taxpayer registered under the Act.

OPIUM POPPY CONTROL ACT. Passed in 1942, this Act prohibits production of the opium poppy in the United States except under license of the Secretary of the Treasury. No license has been issued under this statute.

HARRISON NARCOTIC ACT AMENDMENT. This 1946 amendment to the 1914 Act was made to include synthetic substances having addiction-forming or addiction-sustaining qualities similar to cocaine or morphine.

BOGGS AMENDMENT. In 1951, legislation known popularly as the Boggs Amendment increased penalties for persons violating federal narcotic and marijuana laws, precluded suspension of sentence or probation on second and subsequent offense, and made conspiracy to violate the narcotic laws a special offense. It substituted for the old maximum sentences a series of sentences for repeated offenders as follows:

> First Offense. Not less than two years nor more than five years.
> Second Offense. Not less than five years nor more than ten years with probation and suspension excluded.
> Subsequent Offenses. Not less than ten years nor more than twenty years with probation and suspension excluded.

NARCOTIC CONTROL ACT. As the result of 1955 Congressional investigations of the illicit narcotic traffic, the Narcotic Control Act of 1956 increased and made more inflexible the penalties for narcotic offenders. Parole was excluded in cases of a selling offense and second or subsequent possession offenses. The penalties are as follows:

First Possession Offense. Not less than two nor more than ten years, with probation and parole permitted. Second Possession or First Selling of Narcotics or Marijuana. Not less than five nor more than twenty years, with probation, suspension, and parole excluded. Third Possession or Second Selling and Subsequent Offenses. Not less than ten years nor more than forty years with probation, suspension, and parole excluded.

These penalties carry, in addition, a maximum $20,000 fine. Exclusion of drug offenders from federal parole laws means that they must serve two-thirds of their sentence. Most other federal prisoners are eligible for release under supervision after serving one-third of their sentences.

This Act also banned the possession of heroin and required persons possessing heroin to surrender it to the Secretary of the Treasury within 120 days.

NARCOTICS MANUFACTURE ACT. In 1960, Congress enacted this law authorizing the Secretary of the Treasury to establish quotas limiting the manufacture of natural and synthetic narcotics on the basis of medical and scientific need and to license narcotic manufactures. Under this and other federal laws, the Secretary of the Treasury is the cabinet officer charged with responsibility for investigation of offenses and regulating lawful imports and exports. He acts through the Commissioner of Narcotics, who is the chief officer of the Federal Bureau of Narcotics, and is required to cooperate with the states in the suppression of the abuse of narcotic drugs in their respective jurisdictions.

FEDERAL FOOD, DRUG, AND COSMETIC ACT. The portion of this 1938 Act applicable to drugs is presently found in Section 351 to 360a of Title 21 of the United States Code. Important amendments were made in 1962 (popularly known as the Kefauver-Harris Drug Amendments) and in 1965. The pertinent drug sections of Title 21 may be summarized as follows:

1) Proper labeling is required and the statement, "Warning--May Be Habit-Forming," must be attached to a drug which is for use by man and which contains any quantity of narcotic or hypnotic substance, alpha eucaine, barbituric acid, betaeucaine, bromal, cannabis, cabromal, chloral, coca, cocaine, codeine, heroin, marijuana, morphine, opium, paraldehyde, peyote, or suphonmethane or chemical derivates or the foregoing.

2) Prescription is required for the dispensing of a drug intended for use by man which:

(a) Contains certain narcotic and other substances or substances designated by regulation as "habit-forming,"

(b) Is not safe except under the supervision of a licensed practitioner because of its potentiality for harmful use, or

(c) Is limited to use under the professional supervision of a licensed practitioner under procedures for the introduction of new drugs into interstate commerce.

3) No new drugs may be introduced into interstate commerce unless an application filed with the Secretary of Health, Education and Welfare is in effect with respect to such drug.

4) Annual registration is required of establishments that manufacture, compound, or process drugs and that wholesale or distribute any depressant or stimulant drug. The 1962 Drug Act established registration requirements. The depressant and stimulant drug registrations were added by the Drug Abuse Control Amendments of 1965 which established special federal controls over depressant, stimulant, and hallucinogenic drugs.

Section 301 of the Federal Food, Drug and Cosmetic Act, as amended in 1962 and 1965, enumerates prohibited acts as follows:

Introduction or delivery onto interstate commerce of adulterated or misbranded foods, drugs, devises, or cosmetics.

Their adulteration or misbranding in interstate commerce.

Their receipt and delivery in adulterated or misbranded state.

The introduction or delivery into interstate commerce of any article in violation of temporary permit controls (applicable to food) or in violation of procedures for the introduction of new drugs.

Refusal to permit access to records of interstate shipments of food, drugs, devices, or cosmetics or to make records or reports required under procedures for the introduction of a "new drug."

Refusal to permit entry and inspection of certain establishments in which foods, drugs, devices, and cosmetics are manufactured or held.

Manufacture of adulterated or misbranded foods, drugs, devices, and cosmetics.

The giving of certain false guarantees regarding good faith in receiving or delivering such articles.

Certain false use of identification devices required under law, doing of certain acts which cause a drug to be counterfeit, or the sale, dispensing, or holding for sale or dispensing of a counterfeit drug.

Misuse of trade secret information.

Certain acts resulting in adulteration or misbranding of foods, drugs, devices, or cosmetics in interstate commerce.

Representing or suggesting in labeling or advertising that approval of a new drug application is in effect or that the drug complies with new drug introduction procedures.

Violation of laws governing the coloring of margarine.

The use in sales promotion of any reference to a report or analysis furnished under inspection procedures.

In the case of prescription drugs, failure of the manufacturer, packer, or distributor to maintain or transmit to requesting practitioners true and correct copies of all printed matter required to be included in the drug package.

Failure of drug manufacturers and processors and depressant or stimulant drug wholesalers, jobbers, or distributors to register with the Secretary of Health, Education and Welfare.

Relative to stimulant or depressant drugs: manufacturing, processing, or compounding, except by registered drug firms for legal distribution; distributing such drugs to persons not licensed or authorized to receive them; possession of stimulant or depressant drugs except as authorized by law; failure to prepare, obtain, or keep required records, and to permit inspection and copying of such records; refusal to permit entry or inspection as authorized; filling or refilling prescriptions for these drugs in violation of law.

Imprisonment for not more than one year or a fine of not more than $1,000 or both, is the penalty for violation of any of these prohibitions. If the violation is committed after a previous conviction has become final, or is made with intent to defraud or mislead, the violator is subject to imprisonment for not more than three years or a fine of not more than $10,000 or both.

DRUG ABUSE CONTROL AMENDMENTS. In January, 1963, President Kennedy established a President's Advisory Commission on Narcotic and Drug Abuse. The Commission made 25 recommendations, the influence of these being reflected in the amendments of 1965.

The Drug Abuse Control Amendments of 1965 impose more stringent controls on stimulant, depressant, and hallucinogenic drugs. The new law, which became effective in 1966, begins with a declaration by Congress that these drugs need not move across state lines to be subject to its regulations. The law notes that "in order to make regulation and protection of interstate commerce in such drugs effective, regulation of intrastate commerce is also necessary" because of the difficulties of determining place of origin and consumption and because regulation of interstate but not intrastate commerce "would disciminate against and adversely affect interstate commerce in such drugs."

The amendments add to the body of law a definition of depressant or stimulant drug as:

1) One which contains barbituric acid or its salts or a derivative therefrom which has been designated under federal law as habit forming;

2) One which contains amphetamine or its salts or a substance designated as habit forming by the Secretary of Health, Education and Welfare because of its stimulant effect on the central nervous system; and

3) One containing a substance designated by regulation as having a "potential for abuse" because of its depressant or stimulant effect on the central nervous system or its hallucinogenic effect. Narcotic drugs are specifically excluded.

Lysergic acid and lysergic acid amide are drugs covered by the amendments of 1965, along with mescaline and its salts, peyote, and psilocybin. The Act also prohibits the possession of depressant or stimulant drugs except by seven classes of persons -- who can be generally described as manufacturing or doing research upon the drugs.

No prescription for a depressant or stimulant drug may be filled or refilled more than six months after the date of its issuance, and no refillable prescription may be refilled more than five times. However, prescriptions may be renewed, in writing or orally (if reduced to writing and filed by the pharmacist), by the prescribing practitioner and then again refilled to the same extent as the original prescription.

Further changes to the Drug Abuse Control Amendments to the Federal Food, Drug and Cosmetic Act of 1965 were made in 1968. These changes increase the penalties for anyone who illegally produced, sells or disposes of dangerous drugs, and imposes a misdemeaner penalty for possession.

NARCOTIC ADDICT REHABILITATION ACT. The Narcotic Addict Rehabilitation Act was enacted in 1966 and is a significant effort toward treatment and rehabilitation of narcotic addicts. The legislation, effective February, 1967, provides for civil committment in lieu of prosecution.

NOTE: For a more detailed description of this Act, including its various provisions for committment and treatment and rehabilitation, the reader is referred to Chapter IV - TREATMENT OF DRUG ADDICTION.

*A 1969 Supreme Court decision removed two of the Federal Government's major legal weapons against marijuana traffic when it held that the Marijuana Tax Act is unenforceable when the accused claims the Fifth Amendment privilege against self-recrimination. The Court also declared as unreasonable the law's presumption that a person with marijuana in their possession knows that it was imported illegally, thus violating due process of law.

STATE LAWS. Individual state laws dealing with dangerous drugs are not uniform. Current state laws vary widely in terms of drugs included and the penalties imposed for their possession or use. It is suggested that individuals who are interested in specific state laws dealing with dangerous drugs refer to the law libraries in each of the states (See Appendix G). Many municipalities also have specific ordinances regarding marijuana, narcotics and dangerous drugs and these also may be consulted.

APPENDIX G

DIRECTORY OF STATE AND OTHER LAW LIBRARIES

DIRECTORY OF STATE AND OTHER LAW LIBRARIES[17]

ALABAMA

Alabama Supreme Court Library
Judicial Building
Montgomery, Alabama 36104

ALASKA

Alaska Court Libraries
941 4th Avenue
Anchorage, Alaska 99501

ARIZONA

Department of Libraries and Archives
3rd Floor, Capital Building
Phoenix, Arizona 85007

ARKANSAS

Arkansas Supreme Court Library
Justice Building
Little Rock, Arkansas 72201

CALIFORNIA

California State Library
Law Library
Library and Courts Building
Sacramento, California 95809

COLORADO

Colorado Supreme Court Library
220 Capital Building
Denver, Colorado 80203

CONNECTICUT

Connecticut State Library
231 Capital Avenue
Hartford, Connecticut 06115

DELEWARE

State Library in Kent County
Kent County Court House
Dover, Deleware 19901

DISTRICT OF COLUMBIA

Library of Congress
10 First Street, S.E.
Washington, D.C. 20540

FLORIDA

Attorney General's Law Library
Capital Building
Tallahassee, Florida 32304

GEORGIA

Georgia State Library
301 Judicial Building
Capital Hill Station
Atlanta, Georgia 30334

HAWAII

Hawaii Supreme Court Law Library
P.O. Box 779
Honolulu, Hawaii 96808

IDAHO

Idaho State Law Library
State House
Boise, Idaho 83707

ILLINOIS

Supreme Court Library
Supreme Court Building
Springfield, Illinois 62706

INDIANA

Supreme Court Library of Indiana
316 State Capital
Indianapolis, Indiana 46204

IOWA

Iowa State Law Library
State House
Des Moines, Iowa 50319

KANSAS

State Libraries of Kansas
State House
Topeka, Kansas 66612

KENTUCKY

Kentucky State Law Library
Capital
Frankfort, Kentucky 40601

LOUISIANA

Law Library of Louisiana
Louisiana Supreme Court Building
Civic Center
New Orleans, Louisiana 70112

MAINE

Maine State Library
State House
Auburn, Maine 04330

MARYLAND

Maryland State Library
Court of Appeals Building
P.O. Box 348
Annapolis, Maryland 21404

MASSACHUSETTS

State Library of Massachusetts
341 State House
Boston, Massachusetts 02133

MICHIGAN

Michigan State Library
Law Division, Law Building
P.O. Box 1237
Lansing, Michigan 48904

MINNESOTA

Minnesota State Library
322 State Capital
St. Paul, Minnesota 55101

MISSISSIPPI

Mississippi State Law Library
New Capital
Jackson, Mississippi 39205

MISSOURI

Missouri Supreme Court Library
Supreme Court Building
Jefferson City, Missouri 65101

MONTANA

Montana State Law Library
State Capital
Helena, Montana 59601

NEBRASKA

Nebraska State Library
3rd Floor S., Statehouse
Lincoln, Nebraska 68509

NEVADA

Nevada State Library
Law Section
Supreme Court & Library Building
Carson City, Nevada 89701

NEW HAMPSHIRE

New Hampshire State Library
Law Division
Supreme Court Building
Concord, New Hampshire 03301

NEW JERSEY

New Jersey State Law Library
185 West State Street
Trenton, New Jersey 08625

NEW MEXICO

New Mexico State Library
P.O. Box 1629
Santa Fe, New Mexico 87501

NEW YORK

New York State Library
Education Building
Albany, New York 12224

NORTH CAROLINA

North Carolina Supreme Court Library
Fifth Floor, Justice Building
2 East Morgan Street
Raleigh, North Carolina 27602

NORTH DAKOTA

North Dakota Supreme Court Law Library
2nd Floor, Capital Building
Bismarck, North Dakota 58501

OHIO

Supreme Court Law Library
State House Annex
Columbus, Ohio 43215

OKLAHOMA

Oklahoma Department of Libraries
Law Division
109 State Capital
Oklahoma City, Oklahoma 73105

OREGON

Supreme Court Library
Supreme Court Building
State & 12th Streets
Salem, Oregon 97310

PENNSYLVANIA

Pennsylvania State Law Library
Education Building
Harrisburg, Pennsylvania 17126

PUERTO RICO

Supreme Court Library
P.O. Box 2392
San Juan, Puerto Rico 00902

RHODE ISLAND

Rhode Island State Library
State House
Providence, Rhode Island 02903

SOUTH CAROLINA

South Carolina State Library
1500 Senate Street
Columbia, South Carolina 29201

SOUTH DAKOTA

South Dakota Supreme Court Library
Pierre, South Dakota 57501

TENNESSEE

Tennessee State Library & Archives
State Library Division
Nashville, Tennessee 37219

TEXAS

Texas Supreme Court Library
Supreme Court Building
Capital Station
Austin, Texas 78711

UTAH

Utah State Law Library
332 State Capital Building
Salt Lake City, Utah 84114

VERMONT

Vermont State Library
Montpelier, Vermont 05602

VIRGINIA

Virginia State Law Library
Supreme Court of Appeals Building
P.O. Box 1315
Richmond, Virginia 23210

WASHINGTON

Washington State Law Library
Temple of Justice
Olympia, Washington 98501

WEST VIRGINIA

West Virginia State Law Library
State Capital Building
Charleston, West Virginia 25305

WISCONSIN

Wisconsin State Law Library
310 East - State Capital
Madison, Wisconsin 53702

WYOMING

Wyoming State Library
Law Division
Supreme Court Building
Cheyenne, Wyoming 82001

APPENDIX H

NATIONAL ACTION COMMITTEE: LEADERSHIP TRAINING INSTITUTE

NATIONAL ACTION COMMITTEE--LEADERSHIP TRAINING INSTITUTE[18]

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Consultant for Student Affairs
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Rochester, New York 14627

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Sacramento, California 95814

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American Association for Health, Physical
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Baton Rouge, Louisiana 70806

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Addiction and Drug Abuse
Department of Institutions &
Agencies
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APPENDIX I

INFORMATION SOURCES REGARDING NARCOTICS AND DRUGS

INFORMATION SOURCES REGARDING NARCOTICS AND DRUGS

Addiction Research Center
US Public Health Hospital
Lexington, Kentucky 40501

American Correctional Association
Woodbridge Station
P.O. Box 10176
Washington, D.C. 20018

American Council on Alcohol
Problems, Inc.
119 Constitution Avenue, N.E.
Washington, D.C. 20002

American Medical Association
Department of Mental Health
535 N. Dearborn Street
Chicago, Illinois 60610

American Social Health Association
Earle G. Lippincott
Department of Mental Health
1740 Broadway
New York, New York 10019

Associated Press
Mr. Joe Wing
50 Rockefeller Plaza
New York, New York 10020

Bureau of Drug Abuse Control
New York Field Office
346 Broadway, Twelfth Floor
New York, New York 10013

Bureau of Narcotics and Dangerous Drugs
Division of Drug Education
1405 "I" Street, N.W.
Washington, D.C. 20005

Bureau of Narcotics and Dangerous Drugs
605 US Custom House
Second & Chestnut Streets
Philadelphia, Pennsylvania 19106

Butler University
College of Pharmacy
Indianapolis, Indiana 46205

Commission on Narcotic Drugs
Economic & Social Council
United Nations, New York 10017

Committee for Narcotics
Prevention, Inc.,
Box 500
Morristown, New Jersey 07960

Division of Narcotic Drugs
World Health Organization
United Nations European Office
Geneva, Switzerland

Do It Now Foundation
P.O. Box 3573
Hollywood, California 90028

Drug Abuse Secretariat (Canada)
J.C. Wickett, M.D.
Drug Abuse Secretariat
Department of National Health
and Welfare
Ottawa 3, Ontario, Canada

Essex County Chapter
Morrow Association on Correction
Dr. Sylvia Herz, Chairman
220 Tillou Road
South Orange, New Jersey 07079

Essex County Study Committee
on Narcotic Addiction
Metropolitan State Health District
1100 Raymond Boulevard
Newark, New Jersey 07100

Federal Bureau of Narcotics
Training School
Treasury Department
Washington, D.C. 20026

Greater Philadelphia Council on
Narcotics & Dangerous Drug Abuse
1610 Spruce Street
Philadelphia, Pennsylvania 19103

I/D/E/A
Information & Services Division
P.O. Box 446
Melbourne, Florida 32901

Law Enforcement Assistance
Administration
Office of Law Enforcement Programs
633 Indiana Avenue, N.W.
Washington, D.C. 20530

Merck Chemical Division
Merck & Company, Inc.
Rahway, New Jersey 07065

Monmouth County Chapter, Morrow
Association on Correction
William O'Grady, Chairman
P.O. Box 236
Navesink, New Jersey 07752

Monmouth County Citizen's Committee
on Narcotics
Mrs. G. Caracciola, Chairman
11 Leonard Avenue
Atlantic Highlands, New Jersey 07716

Narcotics Education, Inc.
P.O. Box 4390
Washington, D.C. 20012

National Action Committee
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Rochester, New York 14627

National Association of Student
Personnel Administrators
O.D. Roberts, President
University of Rochester
110 Anderson Hall
Rochester, New York 14627

National Clearinghouse for
Drug Abuse Information
5454 Wisconsin Avenue
Chevy, Chase, Maryland 20015

National Coordinating Council on
Drug Abuse Education & Information,In
Mr. Peter G. Hammond, Executive Directo
P.O. Box 19400
Washington, D.C. 20036

National Education Association
John H. Cooper, P.E.D.
1201 16th Street, N.W.
Washington, D.C. 20036

National Institute of Mental Health
Bethesda, Maryland 20014

National Institute of Mental Health
Drug Abuse Film Collection
Distribution Branch
National Audiovisual Center (GSA)
Washington, D.C. 20409

National Safety Council
Howard Pyle, President
425 N. Michigan Avenue
Chicago, Illinois 60611

National Sex and Drug Forum
Dr. Joel Fort, Co-Director
San Francisco State College
San Francisco, California 94132

National Student Association
Drug Desk
2115 S. Street, N.W.
Washington, D.C. 20008

New Jersey Drug Addiction Program
165 W. Hanover Street
Trenton, New Jersey 08618

New Jersey Drug Study Commission
State House
Trenton, New Jersey 08625

New Jersey Narcotics Advisory Council
68 Central Avenue
Orange, New Jersey 07052

New Jersey Parent's Association
on Drug Addiction
P.O. Box 926
Newark, New Jersey 07100

New Jersey Pharmaceutical Association
118 W. State Street
Trenton, New Jersey 08625

New Jersey Sheriff's Association
Sheriff's Building
Bayard Street
New Brunswick, New Jersey 08901

New Jersey Urban Schools
Development Council
Mr. Raymond Milam, Executive Director
1000 Spruce Street
Trenton, New Jersey 08638

New Jersey WCTU
7 Martin Road
Verona, New Jersey 07044

New Jersey Welfare Council Drug
Study Committee
60 S. Fullerton Street
Montclair, New Jersey 07042

New York State Narcotic Addiction
Control Commission
Executive Park South
Albany, New York 12203

Pharmaceutical Manufacturers
Association
C. Joseph Stetler, President
1155 15th Street, N.W.
Washington, D.C. 20005

Pennsylvania Association of
Retail Druggists
2017 Spring Garden Street
Philadelphia, Pennsylvania 19130

Pennsylvania Department of Health
Institute for Alcohol, Narcotic
Addiction & Compulsive Gambling
915 Corinthian Avenue
Philadelphia, Pennsylvania 19130

Pennsylvania State Narcotic
Control Division
915 Corinthian Avenue
Philadelphia, Pennsylvania 19130

Philadelphia County Medical Society
2100 Spring Garden Street
Philadelphia, Pennsylvania 19130

Public Affairs Committee
22 E. 38th Street
New York, New York 10016

Public Affairs Pamphlets
381 Park Avenue, South
New York, New York 10016

Science Research Associates, Inc.
57 West Grand Avenue
Chicago, Illinois 60610

Seton Hall Medical School
South Orange, New Jersey 07079

Smith, Kline & French Laboratories
Attn: Educational Information
1500 Spring Garden Street
Philadelphia, Pennsylvania 19101

STAND (Students Talk About
Narcotics Danger)
109 E. Main Street
Spartanburg, South Carolina 29301

Temple University
Drug Education Activities
Mitten Hall - Rm. 205
Philadelphia, Pennsylvania 19122

United States Department of Health,
Education & Welfare
Food and Drug Administration
Washington, D.C. 20204

FOOTNOTES

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[3]Ibid., p. 4.

[4]Ibid., p. 109.

[5]Ibid.

[6]Louise G. Richards, Government Programs and Psychological Principles In Drug Abuse Education, (September 3, 1969). Paper presented at the American Psychological Association Convention, Washington, D.C., August 31-September 4, 1969, p. 4.

[7]Drug Abuse: Escape To Nowhere, op. cit., p. 29.

[8]Ibid.

[9]Kitzinger and Hill, op. cit., p. 5.

[10]Ibid.

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United States Department of Health, Education and Welfare, National Clearinghouse for Mental Health Information, Resource Book for Drug Abuse Education, (Washington, D.C.: Government Printing Office, October, 1969). pp. 116-117.

Vincent Maraglia,"Annotated Bibliography Part I - Books and Booklets, Part II - Periodicals, Part III - Pamphlets and Others,"(July, 1969). Mimeographed.

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Films on Drug Abuse Education, National Coordinating Council of Drug Abuse Education and Information, Washington, D.C.

David O. Weber, "Drug Films: How Good are the Best? How Bad are the Worst?" Part I, California's Health, XXVI, No. 2 (August, 1968), pp. 3-7.

_____, "Drug Films: How Good are the Best? How Bad are the Worst?" Part II, California's Health, XXVI, No. 3 (September, 1968), pp. 9-12.

_____, "Drug Films: How Good are the Best? How Bad are the Worst?" Part III, California's Health, XXVI, No. 4 (October, 1968), pp. 7-11.

L. C. Larson, Carolyn Guss and Edward Newren, "Film Evaluations," Educational Screen and Audiovisual Guide, XLVIII, No. 3 (March, 1969), p. 38.

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Drug Abuse: Escape To Nowhere, op. cit., pp. 98-104.

New Jersey State Department of Education, Office of Health, Safety and Physical Education, Drug Abuse: A Reference for Teachers, (Trenton: New Jersey State Department of Education, 1969), pp. 68-71.

[15]Rose Leiman Schiller, The Underground Bird, Plays for Living, A Division of Family Service Association of America. Commissioned and Published by the American Social Health Association.

[16]State of Colorado, Colorado Legislative Council, Dangerous Drugs and Drug Abuse Control, Report to the Colorado General Assembly, Publication No. 127, (Denver: Colorado Legislative Council, December, 1967), pp. 27-32.

[17]Directory of Law Libraries, (Chicago: American Association of Law Libraries, (June, 1970).

[18]United States Department of Health, Education and Welfare, Office of Education, Drug Education Program, (Washington, D.C.: Government Printing Office, April, 1970), p. 4.